

Plan Use Only		Last Name		First Name		Initial		Date of Birth			
Effective Date		Address		City		State		Zip		Home Phone	
Employer		Work Phone		Sex (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address					

**Eligible Dependents**

Name	Relationship	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Name	Relationship	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Name	Relationship	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

On behalf of the above named individuals, I hereby apply for enrollment in The Pearl Plan and certify that the above information is true and correct. I certify that I am over 18 years of age. My enrollment in The Pearl Plan constitutes acceptance of the Terms and Conditions of the Plan as set forth in The Plan Guidelines.

Applicant Signature:  Date:

Make check or money order payable to: Dr. Ashraf Okba, DDS, Inc.

VISA  Mastercard  AmEX  Discover  Check  Cash