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|----------------|--|------------|--|--|--|---------------|--|---------------|--|------------|--|
| 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.

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