

HEALTHPLEX, INC.
DENTCARE DELIVERY SYSTEMS, INC. * INTERNATIONAL HEALTHCARE SERVICES, INC.

EMPLOYER'S NAME _____		GROUP # _____		
MANAGED CARE OPTION				
LAST NAME		FIRST NAME		INITIAL
STREET ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER		TELEPHONE # ()	OTHER DENTAL COVERAGE YES <input type="checkbox"/> NO <input type="checkbox"/>	
BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child <input type="checkbox"/> Family		LOCAL #/RANK
List Name of Spouse and Unmarried Dependent Children (Under 19 Years of Age) To Be Covered		Check Relationship Spse Son Dght	Date of Birth Mo. Day Yr.	
				Select from attached list
				Dr's. Name _____
				Dr's. Code _____
				Effective Date _____

I agree to abide by the terms and conditions of the contract.

SIGNATURE _____
 F-2002

DATE _____