



SYHMP Saint Yared Health Services, LLC
 2711 Centerville Rd Suite 120
 Wilmington, DE 19808
 E-mail: saint.yared@yahoo.com
 Tel: 1-866-60-YARED (92733)

Saint Yared Health Maintenance Plan

Application Form

Complete this application form and mail it with a \$50 application fee per person to cover the required deposit and the fee for the first month's health services. Once we receive your application and the payment, a package will be sent to you, which will include a copy of the policy. The recipient(s) will be contacted and given a membership ID card as well as a copy of the policy.

SPONSOR'S INFORMATION

First Name:	Last Name:	
Address:	Phone Number:	
City:	State:	Zip:
Make check payable to SYHMP and mail application form and payment to: Saint Yared Health Services, LLC 2711 Centerville Rd Suite 120 Wilmington, DE 19808		

PAYMENT INFORMATION (You can pay by check or credit card)

Amount \$ _____.	Credit Card <input type="checkbox"/>	Check <input type="checkbox"/>	Amount \$ _____.
VISA	AMEX	MASTER-CARD	EXPIRATION DATE
Card Number: _____			Three digits on the back of your card
_____ / _____			

I have read the terms and conditions of SYHMP. By signing this form, I hereby authorize SYHMP to charge my credit card the amount shown above.

SIGNATURE

DATE

RECIPIENT 1

RECIPIENT 2

Name:	Name:
Address:	Address:
Home Phone Number:	Home Phone Number:
Mobile Number:	Mobile Number:
Gender (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female

RECIPIENT 3

RECIPIENT 4

Name:	Name:
Address:	Address:
Home Phone Number:	Home Phone Number:
Mobile Number:	Mobile Number:
Gender (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female