LegalShield
Worry Less. Live More.

Corporate Offices: One Pre-Paid Way • Ada, OK 74820
www.LegalShield.com • 800-654-7757
LegalShield is the trade name of Pre-Paid Legal Services, Inc. and its subsidiaries.

Select Applicable Subsidiary:
- ◉ Pre-Paid Legal Services, Inc.
- ○ Pre-Paid Legal Casualty, Inc.
- ○ Legal Service Plans of Virginia, Inc.
- ○ Pre-Paid Legal Services, Inc. of Florida
- ○ Pre-Paid Legal Access, Inc.

OFFICE USE ONLY			
CWA		PLAN	
FOB		FRAN	
MODE		GR#	

EMPLOYEE BENEFIT MEMBERSHIP APPLICATION ◉ MAS

Today's Date ___/___/_____ MM DD YYYY

Time of Day ——— ○A.M. ○P.M.

Please Choose the appropriate plan:
- ○ Standard Plan
- ○ Additional Trial Defense
- ○ IDT ST☐ GOLD☐ MINORS___
- ○ Other _____

A $10 non-refundable fee ($25 for CDLP) is waived due to your employer offering this at work.
Please print LEGIBLY in ALL CAPITAL letters, using ONLY BLUE or BLACK INK.

❶ Personal Information

The information you provide on this application is considered non-public information, and LegalShield takes care to protect your information.

○Mr. ○Mrs. ○Miss. ○Ms. ○Dr. **Applicant's SSN** _____ For Internal Use Only **DOB** ___/___/_____ MM DD YYYY

Applicant's Name _____ Last _____ First ____ MI

***Co-Applicant's Name** _____ Last _____ First ____ MI

(*Co-Applicant refers to Spouse or Domestic Partners, Civil Union Partners, Same-Sex Partners, or other term specifically defined by any local, state or federal statute.)

Address _____ ____ Apt.#/Ste#

_____ City _____ State _____ Zip + 4

Phone # (___) _____ Business ____ Ext. (___) _____ Home (___) _____ Cell

Email _____ (Your privacy is a priority with us! We will not sell your email address or personal information of any kind to third party vendors.)

Please indicate below, on a voluntary basis, if you are either blind or deaf. All information will be kept confidential, and used only to enhance the services provided by LegalShield to its blind and/or deaf associates and members.

○ **Blind** ○ **Deaf**

Associate Use Only

Assigned Associate Number _____ **Business phone** (___) _____

Associate Name _____ Last _____ First ____ MI

Associate SSN Number _____ (If Licensed) **Associate Lic. Number** _____ (In Florida)

Associate Signature X _____

APP.PD (10.12)

2 Dependent Information

If you have more than five (5) dependents, please attach a separate piece of paper.

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

In AL, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **In FL**, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **In NJ**, any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **In OR**, any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information concerning a material fact may be subject to criminal or civil penalties and/or cancellation of the contract. **In TN**, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant: I understand that the written contract sets forth the terms of my membership, including any exclusions or limitations, and agree to be bound by the same. I further understand that the company will mail the written contract to me at the address noted herein within the next fourteen days. If I have not received my contract within that time frame, I understand that it is my responsibility to call LegalShield to obtain a copy. The written contract, together with this application, constitutes the entire agreement between the company and the member with respect to the membership, and there are no agreements, understandings, or representations other than as set forth herein and in the membership contract.

I hereby acknowledge that on this date, I purchased this plan in the city of_____in the state of _____. By signing this application I certify I am legally residing in the United States and agree to the above Authorization of Payment and membership fees selected above.

Employer _____ **Occupation** _____

Signature of Applicant X _____

3 Payroll Deduction Authorization

Today's Date ____/____/_____ (MM/DD/YYYY) **Applicant's SSN** _____ (For Internal Use Only)

Applicant's Name _____ (Last) _____ (First) ____ (MI)

I hereby authorize (Company Name) _____

_____ (City) _____ (State) **to deduct** $ ___.__

per (Circle one: week / month / other _____) from my earnings for my LegalShield, and subsidiaries membership and to remit such amount directly to LegalShield. I agree that the company will not be responsible or liable for my decision to purchase the LegalShield membership or the services provided through my membership and that company's sole responsibility is to withhold and pay my membership fee to LegalShield.

Signature of Applicant X _____

CLEAR FORM