LegalShield

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.

Please Choose plan:

Plan	Family Price (Pay Period)	Individual Price (Pay Period)
LegalShield	$7.98	$7.48
IDShield	$7.98	$4.23
Combined	$14.45	$11.70

Today's Date ___/___/_____ (MM/DD/YYYY) **Time of Day** _____ ○ A.M. ○ P.M.

A $10 non-refundable fee ($25 for CDLP) is waived due to your employer offering this at work.
Home Business Supplement members should attach a document and provide:
1) business name, **2)** tax identification number, and
3) a general description of the business.

1 Personal Information

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

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

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

****Email** _____

*Co-Applicant's Name** _____ (Last) _____ (First) _____ (MI) **DOB** ___/___/_____ (MM/DD/YYYY)

****Email** _____

Address _____ _____ (Apt.#/Ste.#)

_____ (City) _____ (State) _____ (Zip + 4)

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

(*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. Not applicable to Individual plans.)

(**Provide your email to receive member benefits. We do not sell your personal information to any third parties.)

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.

○ **Blind** ○ **Deaf**

Associate Use Only

Associate # _____ **Bus. Phone** (___) _____ **Associate SSN** _____ (If Licensed)

Associate Name _____ (Last) _____ (First) _____ (MI)

Associate Lic. # _____ (In Florida) **Producer Identification Name/Number** _____

APP.PD (5.15)

Associate Signature X _____

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 agree the contract sets forth the terms of my membership. Such terms include any exclusions and limitations. I agree to be bound by the contract, and its terms and conditions, which will be provided to me by LegalShield, unless I cancel the contract, which I may do at any time by calling 1-800-654-7757. LegalShield may send the contract to me at my email address unless I communicate in writing that I do not agree to delivery by electronic means. If I have not listed an email address, or if required by a particular state, the contract will be sent by mail. My membership cards will be sent by mail. I may ask for a mailed copy of the contract at any time, or if I have not received my contract in 10 days from this application, I can request a copy by calling Member Services at 1-800-654-7757. The contract, with this application, is the entire agreement between LegalShield and me with respect to the membership and there are no agreements or representations other than as set forth herein and in the membership contract.

I acknowledge that I purchased this membership plan in the city of _____ in the state of _____.
By signing this application I confirm I am legally residing in the United States and agree to the below Payroll Deduction Authorization, the membership fees selected below, and the terms of the selected membership plan.

Employer **Occupation**

Signature of Applicant X _____