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.

OFFICE USE ONLY			
CWA		PLAN	
FOB	PB	FRAN	302763
MODE	4	GR#	

EMPLOYEE BENEFIT MEMBERSHIP

O MAS

Today's Date ____ / ____ / ____
MM DD YYYY

Time of Day ______ O A.M. O P.M.

Plan Options:

☐ Legal Only - $18.50

☐ Legal + HomeBase Business = $33.45

1 Personal Information

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

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

****Email** ______________________

(*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.)

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

Address ______________________ Apt.#/Ste#

______________ City ______________ State ______________ Zip + 4

Phone # ( ) ______________ Business ______ Ext. ( ) ______________ Home ( ) ______________ Cell

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.

O **Blind** O **Deaf**

Associate Use Only

Assigned Assoc. # Top Broker **Bus. Phone** ( ) ______________ **Associate SSN** 129026514 (If Licensed)

Associate Name ______________ Last ______________ First ____ MI

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

Associate Signature X ______________

APP.PD (1.14)

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 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 the company will send me the membership contract within the next 14 days. If I have not received my contract within that time frame, I understand 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.

Account Holder's Signature X ______________________

Signature of Applicant X ______________________