



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#	

UNIVERSAL MEMBER APPLICATION MAS

Today's Date / / Please Choose plan: Legal Plan Trial Defense Supplement IDT Standard
 IDT Premium Home Business Supplement LPSE CDLP
 Other _____

A \$10 non-refundable fee is required for individual enrollments. The non-refundable enrollment fee for CDLP is \$25. Home Business Supplement and/or Legal Plan for Self-Employed 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.

Applicant's SSN _____ **DOB** / /
For Internal Use Only MM DD YYYY

Applicant's Name _____ **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.)
Last First

****Email** _____

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

****Email** _____

Address _____ Apt.#/Ste#
City State Zip + 4

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

(*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

2 Dependent Information If you have more than three (3) dependents, please attach a separate piece of paper.

Name _____ **DOB** / /
Last First MI MM DD YYYY

Name _____ **DOB** / /
Last First MI MM DD YYYY

Name _____ **DOB** / /
Last First MI MM DD YYYY

Associate Use Only **Assigned Assoc. #** _____ **Bus. Phone** () _____

Associate Name _____ **Associate SSN** _____
Last First MI (If Licensed)

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

APP.UNI (1.14) **Associate Signature** **X** _____

3 Payment Information Fill out the ONE payment option you prefer.

Your credit card charge or check is your receipt.

Please fill out for options below: **OPTION 1 (Bank Draft) or OPTION 2 (Credit Card) payment option**

\$. + \$ = \$.

Monthly /Annual draft/
Charge amount

One-time
enrollment fee

Total enclosed by check,
money order, or charged
to credit card

(If paying by credit
card, I realize my first
charge will include a
one-time enrollment
fee where applicable.)

OPTION 1: **Monthly** Or **Annual Bank Draft** / **Checking Account** (Attach check from account to be drafted.) Or **Savings Account** (Attach verification.) Authorization for Electronic Premium: I authorize LegalShield, to make direct payment by charge/draft of my checking/savings account from the Financial Institution listed below. This authority will remain in effect until you notify us in writing to terminate the authorization.

Account Holders Name _____ **Name of Bank** _____

Address _____ **City** _____ **State** _____ **ZIP + 4** _____

Account # _____ **Transit #** _____

When you provide a check as payment, you authorize LegalShield to convert the paper check to an electronic fund transfer from your account. Funds may be withdrawn from your account as soon as the same day payment is received. Your account will be drafted for the same amount each month on or about the effective date of your membership. You waive your right to notification of continued payment. If the amount or date of your payment changes, we will notify you at least ten days before the payment date.

OPTION 2: **Monthly** Or **Annual Payment by Credit Card** I wish to pay by credit card until I revoke this authorization in writing. I realize my account will be charged each month (or Annually).

Cardholders Name _____ **Last** _____ **First** _____ **MI** _____

Card # _____ **Exp. Date** ____/____ **Billing Zip Code** _____
MM YY

MasterCard **Visa** **Discover** **American Express**

OPTION 3: **Annual Direct Bill** Or **Semi-Annual Direct Bill** I wish to pay Annually/Semi-Annually by check. Checks should be made payable to LegalShield.

Amount enclosed \$. *Must include first payment and enrollment fee.

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 14 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.

Account Holder's Signature _____ **X**

Applicant's Signature _____ **X**