



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 Services, Inc. of Florida
- 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

Today's Date MM / DD / YYYY

Time of Day A.M. P.M.

Please Choose plan:

- Legal Plan Individual Family
- IDShield Individual Family
- Trial Defense Supplement CDLP
- Home Business Supplement
- Other _____

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.

Last 4 only

Mr. Mrs. Applicant's SSN _____

For Internal Use Only

DOB MM / DD / YYYY

**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.)*

Applicant's Name Last _____

First _____

MI _____

**Email _____

*Co-Applicant's Name Last _____

First _____

MI _____

DOB MM / DD / YYYY

**Email _____

MI _____

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

Address _____

Apt.#/Ste.# _____

City _____

State _____

Zip _____

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.

Blind Deaf

Associate Use Only

Associate # 127504546 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