LegalShield

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			
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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

UNIVERSAL MEMBER APPLICATION

Today's Date ___/___/____ (MM / DD / YYYY)

A $10 non-refundable enrollment fee is required for legal plans (CDLP is $25).
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.

Please Choose plan:

- ○ Legal Plan ___Individual ___ Family
- ○ IDShield ___Individual ___ Family
- ○ Trial Defense Supplement ○ CDLP
- ○ Home Business Supplement
- ○ Other _____

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**

2 Dependent Information

If you have more than three (3) 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)

Associate Use Only

Associate # 105595144 **Bus. Phone** 515 238-9266

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

Associate Lic. # (In Florida) _____ **Producer Identification if applicable** _____

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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

(My first charge will include a non-refundable one time enrollment fee when applicable.)

OPTION 1: ○ **Monthly Or** ○ **Annual Bank Draft / ○ Checking Account** (Attach check from account to be drafted) **Or** ○ **Savings Account** (Attach verification)

Account Holders Name _____ **Financial Institution** _____

Address _____ City _____ State _____ ZIP + 4 _____

Account # _____ **Routing #** _____

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, when applicable by law.

OPTION 2: ○ **Monthly Or** ○ **Annual Payment by Credit Card** I wish to pay by credit card until I revoke this authorization or cancel my membership. My account will be charged each month (or annually).

Cardholder's Name _____ Last _____ First _____ MI

Card # _____ **Exp. Date** ___/___ MM YY **Billing Zip Code** _____ ○ **MasterCard** ○ **Discover** ○ **Visa** ○ **American Express**

I authorize LegalShield to make direct payment by charge/draft of my check/savings/credit card account from the Financial Institution listed above. I agree and authorize the amount above be made automatically each month/year until I cancel my membership. I may call LegalShield at 1-800-654-7757 at any time to cancel my membership. Upon my cancellation, I am entitled to a refund on a pro rata basis of my monthly/annual fee, based on the date I cancel. I understand LegalShield will provide me reasonable notice if there is any change in the monthly payment amount.

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 non-refundable 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 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 above Authorization of Payment, the membership fees selected above, and the terms of the selected membership plan.

X _____ **Applicant's Signature**

X _____ **Account Holder's Signature**