LegalShield®
Worry Less. Live More.

EMPLOYEE BENEFIT

membership application

24 HR Phone 877-825-3797

Law Firm: _____

Office Use Only	
CWA	
FOB	
MODE	
PLAN	
FRAN	
GR#	

A $10 non-refundable fee is required for individual enrollments.

member information

Please print.

Today's Date ___ / ___ / ____ (Month / Day / Year)

SSN # XXX - XX - ____

For internal use only by PPLSI. Our privacy policy is available upon request.

Name
Last _____
First _____ MI _____

Mailing Address
Apt./ Ste.# _____
Street Address _____
City _____
State _____ ZIP _____

Primary Member's Date of Birth ___ / ___ / ____ (Month / Day / Year)

Spouse
Last _____
First _____ MI _____

Home Phone ___ - ___ - ____

Email Address _____

Associate Use Only

Assigned Associate Number _____
Associate Name _____
Associate SSN Number (If Licensed) _____
Associate License Number (In Florida) _____
Business Phone _____
Signature of Associate X _____

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 fourteen days. If I have not received m contract within that time frame, I understand that it is my responsibility to call the LegalShield Home Office at 1-800-654-7757 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 not agreements, understandings, warranties or representations other than as set forth herein and in the membership contract.

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any materially false, incomplete, or misleading information concerning a material fact is guilty of a felony of the 3rd degree.

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 of America.

Dependents

Last / First / MI	Date of Birth
	/ /
	/ /
	/ /

payroll deduction authorization

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.

Date _____ Applicant signature: X _____