

Employer Name: _____

Select Benefit Plan Administrators

- Your effective date of coverage will be **January 1, 2010**.
- Print the names of all eligible dependents including all unmarried children (*including adopted, step, and foster children*) under 19 years of age who have the same address as you, the Subscriber, or are full time students. Unmarried children under 23 years of age who are pursuing a recognized course of study at high school, college or university are also eligible.
- Select your Plan Attorney Firm from the list on the reverse side. You must choose a law firm from the state in which you reside. Print your choice on the bottom of this application. Remember to fill in the name of your employer at the top of this application and to sign and date it.
- A total of \$18.50 per month will be deducted. A one-time \$20.00 enrollment fee will also be deducted from your first pay period.
- Please return this enrollment form to your Benefits Manager by the end of open enrollment.



You will receive your Subscriber Membership Card with your Plan Attorney Firm's name and phone number in the mail. If you have questions or need additional information, please call Barbara Geiger at 301-654-9490.

SUBSCRIBER ENROLLMENT FORM PAYROLL DEDUCTION GROUP PLAN

P/D START DATE: _____

| | | |
|-----------------------------------|---------------|--------------------|
| SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX |
| LAST NAME (<i>Please Print</i>) | FIRST | MIDDLE |
| ADDRESS | CITY | STATE ZIP |
| HOME PHONE | EMAIL ADDRESS | |
| WORK PHONE | EMPLOYER | DATE OF EMPLOYMENT |

List all eligible dependents (wife / husband / children):

| Relationships | Name (Last) (First) (MI) | DATE OF BIRTH | SEX | √Check if: | |
|---------------|-----------------------------|---------------|-----|------------|----------|
| | | MO. DAY YR. | | STUDENT | DISABLED |
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

I have received a copy of the Summary of Services and I hereby apply for enrollment and coverage with **LEGAL RESOURCES** for pre-paid legal services.

I understand Legal Resources agrees to provide the covered attorney services. **I agree to pay the monthly fee, through payroll deduction, for a minimum of 12 months.**

This agreement shall automatically renew annually on the anniversary date unless Legal Resources is notified in writing 30 days prior to the anniversary date to cancel this agreement.

I understand that the monthly fee is due in advance. I am not responsible for attorney fees for covered services; however, I am responsible for miscellaneous costs associated with any legal matters pertaining to me or a covered family member. I agree that if I cancel my contract within 12 months from the effective date of coverage, I will pay all costs and fees for services rendered which exceed the amount of monthly fees paid during the term.

| | | |
|---|--|---|
| SELECT THE PLAN ATTORNEY FIRM OF: _____ PLAN ATTORNEY FIRM (<i>PLEASE PRINT</i>) | LOCATION OF LAW FIRM _____ | _____ APPLICANT SIGNATURE _____ DATE |
|---|--|---|

SUBSCRIBER COST

Monthly Fee: \$18.50
\$20.00 Enrollment Fee

| |
|------------------------------------|
| FOR OFFICE USE ONLY |
| EFFECTIVE DATE: _____ AGENT: _____ |

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