This Form is to be completed at the time of presentation. All Changes or waivers can be made up to Effective date, Or within 30 days of Today.

Employee Benefit **Enrollment Form**

Employee Name: _________________________________DOB____/____/_____Last 4 SSN __________

Address: ________________________________City__________________ State:____ Zip:___________

Phone/Cell: ______________________Alt/2nd line: __________________Work #: _______________

Spouse/Co-Applicant: ____________________________________DOB_____/_____/_______

Child/Dependent____DOB _____/_____/_______

Child/Dependent____DOB _____/_____/_______

Child/Dependent____DOB _____/_____/_______

Child/Dependent____DOB _____/_____/_______

As an employee of ___________________________, in (City)_____________________,(St)_______, I acknowledge that the LegalShield 24/7 Life Events Legal Plan and IDShield employee benefits were made available and explained to me completely. I have seen the brochure/flat sheet listing specific benefit and benefit limitations of these plans. I authorize my employer to deduct premium from my earnings and remit to LegalShield.

**Pricing reflects 2x-Monthly (24 Pay Periods)

LegalShield Only	Family IDShield	Emp Only IDShield	Emp Only Combined	Family Combined
$9.48	$9.48	$4.48	$13.95	$16.95

Make Coverage Selection by placing an X in the box under plan type.

☐ I Choose to Waive Participation in All Offers at this time.

Applicant: I understand the written contract sets forth the terms of my membership, including any exclusions or limitations, and I agree to be bound by the same. I further understand the Company will email the written contract to me at the address noted herein within fourteen days of the effective date of service. If I have not received my contract within that time frame, I understand it is my responsibility to call LegalShield Member Services at 1-800-654-7757 to obtain a copy. The written contract, together with this enrollment form, 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.

I hereby acknowledge that on this date, I purchased this plan in the City of ___________________________, In the State of_________. By signing this enrollment form, I certify I am legally residing in the United States of America.

Signature of Employee: ____________________________________ Today's Date: ____________

Email____ Benefit Effective Date: ____________

Contact Your Independent Associate

Rich Ellerman 217-316-9729

EllermanCM@gmail.com

- Turn completed form in to your HR / Benefits Department. Download the appropriate APP on mobile devices.