



**Team Liberty Benefits
Prescription Plan**
 Mail to: Support Offices
 333 West Main Street
 Suite 130
 Ardmore OK 73401
 Fax: 580-226-7194
 Support offices: 580-226-5423

Support Office Use Only

_____RCVD
 _____ENTRD
 _____ORDR

PLEASE PRINT CLEARLY

				Today's Date:
<i>Please Print</i>	Name: (First)	(Middle)	(Last)	DOB
Primary Member				
Spouse				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Address:		City:		
State:	Zip:	Home Phone:	Work Phone:	

PAYMENT INFORMATION (Check which applies)

Select Payment Option Monthly

My Initial Payment is being made by: Check Money Order Electronic Check Credit Card

My monthly payment will be automatically deducted from: Bank Draft Credit Card

Name of Bank _____ *Please attach a voided check*

Account Number _____ Routing Number _____

Credit Card Information Visa MasterCard Discover Amex

Credit Card Number _____ Expiration Date _____

Applicant Signature _____

Plan Selection

RX Plan (Includes Family)	\$29.95	One Time Application Fee	\$20.00
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Sellers Name: _____ **Liberty ID #:** RG - 22855901

Effective Dates

Walk-In 1st and 15th of Month

Home Delivery Mail Order – Access Immediately

THIS IS NOT INSURANCE