Team Liberty Benefits Prescription Plan

Mail to: Support Offices
6326 Rucker Road
Suite H
Indianapolis, IN 46220
Phone: 877-867-5423
Fax: 317-731-4485

Support Office Use Only

________________ *RCVD*

________________ *ENTRD*

________________ *ORDR*

PLEASE PRINT CLEARLY

Today's Date:

Please Print	*Name: (First)*	*(Middle)*	*(Last)*	*DOB*
Primary Member				
Spouse				
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**

Sellers Name: IBC______________________________ **Liberty ID #:** 31236701______________________

Effective Dates

Local Walk-In Pharmacy - The next Monday after your entry date. (excluding weekends)

Home Delivery Mail Order – Access Immediately

THIS IS NOT INSURANCE

Form 41072 06/09 © 2009 Team Liberty Benefits, Team Liberty, Liberty Benefits, Liberty Legal, LibertyRx and it's logos are the Registered Trademarks of Liberty Benefits, Inc.