



**Team Liberty Benefits
Prescription Plan**
 Mail to: Support Offices
 333 West Main Street
 Suite 130
 Ardmore OK 73401
 Fax: 580-226-7194
 Support offices: 580-226-4061

<i>Support Office Use Only</i>	
_____	RCVD
_____	ENTRD
_____	ORDR

PLEASE PRINT CLEARLY

Today's Date: _____

<i>Please Print</i>	<i>Name: (First)</i>	<i>(Middle)</i>	<i>(Last)</i>	<i>DOB</i>
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

Single RX Plan	<input type="checkbox"/> \$29.95	One-Time Application Fee Waived for Minnesota Professional Fire Fighters	\$20.00
Family RX Plan	<input type="checkbox"/> \$29.95		

Sellers Name: _____ MPFF **Liberty ID #:** _____ 32861301

Effective Dates

Walk-In 1st and 15th of Month

Home Delivery Mail Order – Access Immediately



THIS IS NOT INSURANCE