



**Team Liberty Benefits  
Prescription Plan**  
 Mail to: Support Offices  
 333 West Main Street  
 Suite 285  
 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>	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**

Single RX Plan	<input type="checkbox"/> \$24.95	<b>One Time Application Fee</b>	<b>\$20.00</b>
Family RX Plan	<input type="checkbox"/> \$29.95		

**Sellers Name:** \_\_\_\_\_    **Liberty ID #:** \_\_\_\_\_

**Effective Dates**

**Walk-In 1st and 15th of Month**

**Home Delivery Mail Order – Access Immediately**



**THIS IS NOT INSURANCE**