



**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

<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

RX Plan (Includes Family)	\$29.95	One Time Application Fee	\$30.00
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Sellers Name: _____ **Liberty ID #:** _____

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