Team Liberty Benefits Prescription Plan

Mail to: Liberty Benefits
6326-H Rucker Rd
Indianapolis, IN 46220

Fax: 317-916-2457
Liberty Offices: 317-916-0722

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**	**$30.00**

Sellers Name: RG - 22855901 **Liberty ID #:** RG - 22855901

Effective Dates

Walk-In Monday after card is received

Home Delivery Mail Order – Day after enrollment

THIS IS NOT INSURANCE

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