

Montgomery College Enrollment Application for Legal Resources

1. Your effective date of coverage is **January 1, 2009**.
2. Print the names of all eligible dependents including all unmarried children (including adopted, step, and foster children) under 19 years of age who have the same address as you, the Subscriber, or are full time students. Unmarried children under 23 years of age who are pursuing a recognized course of study at high school, college or university are also eligible.
3. Select your Plan Attorney Firm from the list provided. You must choose a law firm from the state in which you reside. Print your choice on the bottom of this application. *Remember to sign and date your application.*
4. **FOR NON FACULTY EMPLOYEES (12 Month Staff):** Payroll deduction will begin in December and a total of \$18 per month (\$9 per pay check) will be deducted. Deductions will occur twice per month.
5. **FOR FACULTY AND 10 MONTH STAFF EMPLOYEES ONLY:** If you are a faculty member or 10 month staff member, you will be payroll deducted over a 10 month period beginning in December (\$10.80 per pay period).
6. Please return this enrollment form to Human Resources by the end of Open Enrollment.



You will receive your Subscriber Membership Card with your Plan Attorney Firm's name and phone number in the mail. If you have questions or need additional information, please call Sue Johnson at 301-654-9490.

SUBSCRIBER ENROLLMENT FORM PAYROLL DEDUCTION GROUP PLAN

AMOUNT PAID:

P/D START DATE:

SOCIAL SECURITY NUMBER (REQUIRED)		DATE OF BIRTH		SEX	
LAST NAME <i>(Please Print)</i>		FIRST		MIDDLE	
ADDRESS		CITY		STATE	
HOME PHONE		EMAIL ADDRESS		ZIP	
WORK PHONE		EMPLOYER		DATE OF EMPLOYMENT	

List all eligible dependents (wife / husband / children):

Relationships	Name (Last) (First) (MI)	DATE OF BIRTH			SEX	√Check if:	
		MO.	DAY	YR.		STUDENT	DISABLED
Spouse							
Child							
Child							
Child							

I have received a copy of the Summary of Services and I hereby apply for enrollment and coverage with **LEGAL RESOURCES** for pre-paid legal services.

I understand Legal Resources agrees to provide the covered attorney services. **I agree to pay the monthly fee, through payroll deduction, for a minimum of 12 months.**

This agreement shall automatically renew annually on the anniversary date unless Legal Resources is notified in writing 30 days prior to the anniversary date to cancel this agreement.

I understand that the monthly fee is due in advance. I am not responsible for attorney fees for covered services; however, I am responsible for miscellaneous costs associated with any legal matters pertaining to me or a covered family member. I agree that if I cancel my contract within 12 months from the effective date of coverage, I will pay all costs and fees for services rendered which exceed the amount of monthly fees paid during the term.

<u>I SELECT THE PLAN ATTORNEY FIRM OF:</u> _____ PLAN ATTORNEY FIRM (PLEASE PRINT)	<u>LOCATION OF LAW FIRM</u> _____	_____ APPLICANT SIGNATURE DATE
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SUBSCRIBER COST
 Monthly Fee: \$18.00
 Waived Enrollment Fee

FOR OFFICE USE ONLY
EFFECTIVE DATE: _____ AGENT: _____

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