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This area for LRFA office use only
Effective Date:
Cert.#

EMERGENCY ACCIDENT & HEALTH BENEFIT PLAN FOR VISITORS ABROAD

APPLICATION

LRFA MEMBER'S INFORMATION

Member's Last Name | First Name | MI | LRFA, Inc. Member #

Member's Address

Member's Address Line 2

Phone | E-mail

VISITOR'S INFORMATION

Visitor's Last Name | First Name | MI | Date of Birth

Visitor's Address in Home Country

Arrival Date in USA (MM/DD/YY) | Passport # | Country of Issue

Beneficiary | Relationship

COVERAGE DATES & PLAN

EFFECTIVE DATE Month / Day / Year

DEPARTURE DATE Month / Day / Year

PERIOD OF COVERAGE Months

Effective date will be the latest of: 1) date of arrival, 2) date requested or 3) date application and premium are received.

Coverage automatically terminates when covered person departs the United States.

PLEASE SELECT COVERAGE PLAN:

☐ **Benefit Plan A** ☐ **Benefit Plan B**

PAYMENT FOR COVERAGE DUE

	NAME	AGE	MONTHLY PREMIUM
Covered Person			$
Dependent Child			$
Dependent Child			$
Dependent Child			$
Dependent Child			$
	Total Monthly Payment		$

	NUMBER OF MONTHS		TOTAL
X		**=**	$

A month begins on the effective date of coverage and terminates on the same date of following month.

EXAMPLE:

April 9 to May 8 = 1 month

April 9 to May 9 = 2 months

SIGNATURE

I agree to all the terms of the LRFA Emergency Accident & Health Benefit Plan for Visitors From Abroad. I understand that this is not a general health insurance, and that it is intended for use in the event of a sudden and unexpected sickness or accident. I understand that pre-existing conditions are not covered. I will inform the covered person of these terms.

LRFA Member's Signature | Date