LRFA
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This area for LRFA office use only
LRFA Member #
Effective Date
Waiting Period

Hospital Supplemental Plan Application

PERSONAL INFORMATION

☐ Male ☐ Female

Last Name **First Name**

#

Date of Birth **LRFA Member**

Mailing Address

Mailing Address

Phone **E-mail**

Are you currently pregnant? ☐Yes ☐No **Are you a smoker?** ☐Yes ☐No

Name & Phone # of Primary Physician (PCP):

Please indicate any major medical conditions you have experienced:

AIDS	☐Yes ☐No	Heart Attack	☐Yes ☐No	Muscular Dystrophy	☐Yes ☐No
ALS	☐Yes ☐No	Stroke	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
		Cancer	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Other:	☐Yes ☐No	If "Yes" Please Specify:			

COVERAGE

The Hospital Supplemental Plan provides monetary compensation for each day of a hospital stay, regardless of any other health coverage the individual may have. Please read the regulations for more complete information.

Please ☐ enroll me in OR ☐ transfer me to

the Hospital Supplemental Plan checked below:

☐ Group I ☐ Group II ☐ Group III ☐ Spec Group A ☐ Spec Group B

SIGNATURE & CONFIRMATION

I am fully aware of the regulations for the LRFA Hospital Supplemental Plan and the information I have provided is accurate and complete. I understand that a minimum of 12 months of enrollment is expected and early termination conditions may apply. My benefit coverage will begin on the 1st of the month, following the initial date of admittance into my selected plan. Monthly fees are due no later than the 10th of each month.

Signature **Date**