LRFA

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FOR LRFA OFFICE USE ONLY
LRFA Member #
Effective Date:
Waiting Period:

MEDICARE SUPPLEMENTAL PLAN APPLICATION

PERSONAL INFORMATION

#

Last Name **First Name** **LRFA Member**

☐ Male ☐ Female - -

Gender **Date of Birth** **Medicare Number**

Address

City **State** **Zip**

Phone **E-mail**

Emergency Contact **Relationship**

Contact Phone Number **Contact E-mail**

COVERAGE

☐ Please enroll me in the following Medicare Supplemental Plan or Plans:

☐ Please transfer me from my current Medicare Supplemental Plan or Plans to the following:

☐ **M-Basic** ☐ **M-1** ☐ **M-2** ☐ **M-3**

☐ **M-4** ☐ **M-5** ☐ **M-6** ☐ **M-7**

Coverage to begin on the 1st of _____.
Month

Persons who are on MEDICAID, disability or other government medical assistance programs are not eligible to enroll in the LRFA Medicare Supplemental Plans.

SIGNATURE

I agree to all terms of the LRFA Medicare Supplemental Plan and the information I have provided is accurate and complete.

Signature **Date**