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

Health Supplemental Plan Application

PERSONAL INFORMATION

☐ Male ☐ Female

Last Name **First Name**

#

Date of Birth **LRFA Member**

Mailing Address

Mailing Address

Phone **E-mail**

Children's Names and Dates of Birth (if adding your dependents to your plan)

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

H1*	☐ **20%**	**H2** ☐ **20%**	**H3** ☐ **20%**
	☐ **50%**	☐ **50%**	☐ **50%**
	☐ **80%**	☐ **80%**	☐ **80%**

☐ **Yes!** Please add my children to the above selected Health Plan (list names and ages above)

☐ ***H1**: *I have attached a copy of my primary health insurance card (required)*

SIGNATURE & CONFIRMATION

I am fully aware of the regulations for the LRFA Health 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**