LATVIAN RELIEF FUND OF AMERICA, INC.
P.O. BOX 8857, ELKINS PARK, PA 19027–0857
Phone: 215–635–4137 Fax: 215–635–1583

SUPPLEMENTAL HEALTH CARE BENEFIT REQUEST FORM

This area for LRFA use only

Gr. _____ ☐ Individ
Gr. _____ ☐ Group _____ (month / day / year)

Benefits from Supplemental Health Care

Form#

From gr. _____ $_____
From gr. _____ $_____
_____ $_____

Total benefits: $_____

_____ (month / day / year)
_____ (signature)

Due to hospitalization and my coverage in SUPPLEMENTAL HEALTH CARE PLAN, I hereby submit the following information and request the corresponding benefits:

1. **Name** _____ (last name, first name) **Member. #** _____
2. **Date of Birth** _____ (month / day / year) **Phone #** _____
3. **Address** _____ (please print clearly)
   _____ (city) (state) (zip)
4. **Type of illness or surgery** _____
5. **In – patient care** (hospitalization or annual check–up) **from** _____ (month / day / year) **to** _____ (month / day / year)
6. **Outpatient** **from** _____ (month / day / year) **to** _____ (month / day / year)
7. **If the medical services or surgery have been due to an accident, please specify the date and place of the accident and what kind of injury.**
   _____ (at work,home, traveling, exercising)
   _____ (type of injury)
8. **If the accident took place at work, or the medical problem has been caused by work conditions, please note the name and address of work place.**
   _____ (name and address of workplace)
9. **Name & address of hospital** _____
10. **Doctor's name, who rendered the initial treatment.** _____

I hereby certify that the foregoing information is true and accurate and I have read and fully understand the regulations of the LRFA Supplemental Health Care Benefit Plan

_____ Signature _____ (month / day / year)