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**
		- -
Date of Birth		**Medicare Number**
Address		
City	**State**	**Zip**
Phone	**E-mail**	
Emergency Contact	**Relationship**	
Contact Phone Number	**Contact E-mail**	
Name & Phone Number of Primary Care Provider (PCP)		

Please indicate any major medical conditions you have or 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	Long COVID-19	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Other:	☐Yes	☐No	If *Yes*, please specify:					

COVERAGE

☐ Please enroll me in the following Medicare Supplemental Plan(s):

☐ Please transfer me from my current LRFA Medicare Supplemental Plan(s) to the following:

☐ **M-Basic** ☐ **M-1** ☐ **M-2** ☐ **M-3** ☐ **M-4** ☐ **M-6** ☐ **M-7**

Coverage to begin on the 1st of _____.
Month

☐ ***I have attached a copy of the front and back of my Medicare card (required)***

Persons who are enrolled in Medicare Advantage, Medicaid, or other US 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**