LRFA

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

HEALTH SUPPLEMENTAL PLAN APPLICATION

PERSONAL INFORMATION

Last Name | **First Name** | **LRFA Member #**

☐ Male ☐ Female

Gender | **Date of Birth**

Address

City | **State** | **Zip**

Phone | **E-mail**

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

Name & Phone Number of Primary Care Provider (PCP)

Are you currently pregnant? ☐Yes ☐No

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

H1* ☐ **20%** ☐ **50%** ☐ **80%**

H2 ☐ **50%** ☐ **80%**

H3 ☐ **50%** ☐ **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

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

Signature | **Date**