LRFA

PO Box 8857
Elkins Park, PA 19027

T 215.635.4137 / info@LRFA.org
F 215.635.1583 / www.LRFA.org

FOR LRFA OFFICE USE ONLY

LRFA Member #

Effective Date:

Waiting Period:

FINAL EXPENSE PLAN APPLICATION

PERSONAL INFORMATION

Application for: ☐ **Adult** ☐ **Child** (*under age of 18*) ☐ Male ☐ Female

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

Date of Birth

Address

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

Phone | **E-mail**

BENEFIT PLANS

☐ **Enroll me in the following plans:** *(number of plans is unrestricted)*

☐ **Increase my existing coverage to include the following plans:**

☐ **Plan E** ☐ **Plan F** ☐ **Plan F Free** (Children under 10) ☐ **Plan G**

☐ **Plan H** ☐ **Plan I** ☐ **Plan J**

Enrollment to begin on the 1st of _____ (month).

BENEFICIARY

Last Name | **First Name** | **Relationship**

Address | **Date of Birth**

City, State, Zip

Phone | **Email**

In the event my beneficiary is deceased or cannot be located with reasonable efforts, I wish to donate my Final Expense Plan benefits to LRFA. Please initial: _____

CHILD'S PARENT / LEGAL GUARDIAN (if applicable)

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

Address

Address

Phone | **E-mail**

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Last Name	First Name	# LRFA Member

The LRFA Final Expense Plan is open to all LRFA Members. No medical exam is required, but LRFA may ask some health questions to determine eligibility and rates in certain cases. Disability alone is not a disqualifying factor. This Plan is not a life insurance policy. Benefits can be paid out to any beneficiary of the Member's choice. All health information is confidential and for internal LRFA purposes only.

HEALTH & DISABILITY INFORMATION

Name & Phone Number of Primary Care Provider (PCP)

_____

Are you currently pregnant? ☐ YES ☐ NO

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	COVID-19	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Other:	☐Yes	☐No	Any "Yes", enter date/outcome:					

Have you been hospitalized in the past 12 months? ☐ YES ☐ NO

Reason:_____

Have you ever been diagnosed with a terminal illness? ☐ YES ☐ NO

Diagnosis:_____

Do you have a disability? ☐ YES ☐ NO

What type of disability do you have?

☐ Physical ☐ Vision ☐ Hearing ☐ Intellectual ☐ Other

Additional info: _____

_____

_____

SIGNATURE

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

_____

Signature **Date**