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

Effective Date:

Cert.#

MEDICAL PLAN FOR VISITORS FROM ABROAD

LRFA MEMBER'S INFORMATION

Member's Last Name	First Name	LRFA Member #
Member's Address		
City	**State**	**Zip**
Phone	**E-mail**	

COVERED PERSON'S INFORMATION

Visitor's Last Name	First Name	Date of Birth
Visitor's Address in Home Country		
Arrival Date in USA (MM/DD/YY)	**Passport #**	**Country of Issue**
Beneficiary	**Relationship**	

COVERAGE DATES AND PLAN

EFFECTIVE DATE ____ / ____ / ____ (Month / Day / Year)

DEPARTURE DATE ____ / ____ / ____ (Month / Day / Year)

PERIOD OF COVERAGE ____ Months

Effective date will be the latest of: 1) date of arrival, 2) date requested or 3) date application and premium are received.

Coverage automatically terminates when covered person departs the United States.

PLEASE SELECT COVERAGE PLAN:

☐ **Benefit Plan A** ☐ **Benefit Plan B**

PAYMENT FOR COVERAGE DUE

	NAME	AGE	MONTHLY PREMIUM
Covered Person			$
Dependent Child			$
Dependent Child			$
Dependent Child			$

Payments are calculated on a 30 day basis.

				NUMBER OF 30 DAY PERIODS		TOTAL
	Total Monthly Payment	$	**X**		**=**	$

SIGNATURE

I agree to all terms of the LRFA Medical Plan for Visitors From Abroad and the information I have provided is accurate and complete. I understand that this is not general health insurance, and that it is intended for use in the event of a sudden and unexpected sickness or accident.

Signature **Date**