



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.#

LRFA MEMBER'S INFORMATION

		#
Member's Last Name	First Name	LRFA Member
Passport Number	Name & Phone Number of Primary Care Provider (PCP)	
Member's Address		
City	State	Zip
Phone	E-mail	
Beneficiary	Relationship	

COVERAGE DATES & PLAN

DESTINATION	Effective date will be the latest of: 1) date of departure, 2) date requested, or 3) date application and premium are received.		
EFFECTIVE DATE	Month	Day	Year
RETURN DATE	Month	Day	Year
PERIOD OF COVERAGE	days		

PLEASE SELECT COVERAGE PLAN:
 Benefit Plan A Benefit Plan B

PAYMENT FOR COVERAGE DUE

Maximum period of coverage is eight (8) months

	Name	Date of Birth	Age	# of Days	Payment
Covered Person					
Dependent Child					
Total Payment:					

EXAMPLES:
For 1 to 15 day travel - 15 day rate applies
For 16 to 30 day travel - 30 day rate applies
For 31 to 45 day travel - 15 day rate + 30 day rate applies
For 46 to 60 day travel - 2 x 30 day rate applies
(include both the departure and return dates in your total day count)

SIGNATURE

I agree to all terms of the LRFA Travel Medical Plan 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
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TRAVEL MEDICAL PLAN APPLICATION