LRFA

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

HOSPITAL SUPPLEMENTAL PLAN APPLICATION

PERSONAL INFORMATION

Last Name	First Name	LRFA Member #
☐ Male ☐ Female		
Gender	**Date of Birth**	
Address		
City	**State**	**Zip**
Phone	**E-mail**	

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	Tuberculosis ☐Yes ☐No

Other: ☐Yes ☐No If "Yes" Please Specify: _____

COVERAGE

The Hospital Supplemental Plan provides monetary compensation for each day of a hospital stay, regardless of any other health coverage the individual may have. Please read the regulations for more complete information.

Please ☐ enroll me in OR ☐ transfer me to

the Hospital Supplemental Plan checked below:

☐ Group I ☐ Group II ☐ Group III ☐ Spec Group A ☐ Spec Group B

SIGNATURE

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

Signature **Date**