



# 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:

### PERSONAL INFORMATION

Last Name		First Name	LRFA Member #
<input type="checkbox"/> Male <input type="checkbox"/> Female		-	-
Gender	Date of Birth	Medicare Number	
Address			
City	State	Zip	
Phone	E-mail		
Emergency Contact	Relationship		
Contact Phone Number	Contact E-mail		

### COVERAGE

Please enroll me in the following Medicare Supplemental Plan or Plans:

Please transfer me from my current Medicare Supplemental Plan or Plans to the following:

<input type="checkbox"/> M-Basic	<input type="checkbox"/> M-1	<input type="checkbox"/> M-2	<input type="checkbox"/> M-3
<input type="checkbox"/> M-4	<input type="checkbox"/> M-5	<input type="checkbox"/> M-6	<input type="checkbox"/> M-7

Coverage to begin on the 1st of \_\_\_\_\_ Month.

***I have attached a copy of the front and back of my Medicare card (required)***

*Persons who are on Medicare Advantage, MEDICAID, disability or other government medical assistance programs are not eligible to enroll in the LRFA Medicare Supplemental Plans.*

### SIGNATURE

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

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE SUPPLEMENTAL PLAN APPLICATION**