# 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:

# HEALTH SUPPLEMENTAL PLAN APPLICATION

## PERSONAL INFORMATION

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

☐ Male ☐ Female

**Gender** | **Date of Birth**

**Address**

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

**Phone** | **E-mail**

**Children's Names and Dates of Birth** (if adding dependents to your plan)

**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 | COVID-19 | ☐Yes ☐No | Tuberculosis | ☐Yes ☐No |
| Other: | ☐Yes ☐No | If "Yes" Please Specify: | | | |

## COVERAGE

**H1*** ☐ **20%** ☐ **50%** ☐ **80%**

**H2** ☐ **50%** ☐ **80%**

**H3** ☐ **50%** ☐ **80%**

☐ **Yes!** Please add my children to the above selected Health Plan (list names and ages above)

☐ ***H1**: *I have attached a copy of my primary health insurance card (required)*

## SIGNATURE

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

**Signature** | **Date**