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:

FINAL EXPENSE PLAN APPLICATION

PERSONAL INFORMATION

Application for: ☐ **Adult** ☐ **Child** (*under age of 18*)

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

COVERAGE

☐ Please enroll me in the following plans *(number of plans is unrestricted)*

☐ Please supplement my existing coverage to include the following plans:

☐ **Plan E** ☐ **Plan F** ☐ **Plan G**

☐ **Plan H** ☐ **Plan I** ☐ **Plan J**

Coverage to begin on the 1st of _____.
Month

BENEFICIARY

Last Name	First Name	Relationship
Address		Date of Birth
Address		Phone

In the event my beneficiary is deceased or cannot be located with reasonable efforts, I wish to donate my mortuary benefits to the LRFA, Inc. Please initial: _____

CHILD'S PARENT / GUARDIAN

Last Name	First Name	# LRFA Member
Address	- - Social Security Number	
Address		
Phone	E-mail	

Please complete health information on page 2 and return form to LRFA with your signature.

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Last Name	First Name	# LRFA Member

The LRFA Final Expense Plan is open to all LRFA Members. No medical exam is required, but LRFA may ask some health questions to determine eligibility and rates in certain cases. Disability alone is not a disqualifying factor. This Plan is not a life insurance policy. Benefits can be paid out to any beneficiary of the Member's choice.

HEALTH & DISABILITY INFORMATION

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" Specify:					

Have you been hospitalized in the past 12 months? ☐ YES ☐ NO

Reason:_____

Have you ever been diagnosed with a terminal illness? ☐ YES ☐ NO

Diagnosis:_____

Do you have a disability?
☐ YES ☐ NO

Do you qualify for any of these benefits?
☐ SSI ☐ SSDI ☐ Medicaid

What type of disability do you have?
☐ Physical ☐ Vision ☐ Hearing ☐ Intellectual ☐ Other

Additional info: _____

_____

SIGNATURE

I agree to all terms of the LRFA Mortuary Benefit Plan and the information I have provided is accurate and complete. (*Parent or guardian signature if Child application*)

_____
Signature Date

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