



LRFA

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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	Coverage automatically terminates when covered person returns to the Home Country.
/ /				
RETURN DATE	Month	Day	Year	
PERIOD OF COVERAGE	days			PLEASE SELECT COVERAGE PLAN: <input type="checkbox"/> Benefit Plan A <input type="checkbox"/> 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