# LRFA

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

# MEDICARE SUPPLEMENTAL PLAN APPLICATION

## PERSONAL INFORMATION

#

**Last Name** **First Name** **LRFA Member**

☐ Male ☐ 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:

☐ **M-Basic** ☐ **M-1** ☐ **M-2** ☐ **M-3**

☐ **M-4** ☐ **M-5** ☐ **M-6** ☐ **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.

**Signature** **Date**