



LRFA EMERGENCY ACCIDENT & HEALTH BENEFIT PLAN FOR VISITORS FROM ABROAD
 P.O. Box 8857 • Elkins Park, PA 19027 • Tel. 215-635-4137 • Fax 215-635-1583 • E-pasts: alp@comcast.net

APPLICATION

This area for LRFA office use only

LRFA Member #

Effective Date

Waiting Period

LRFA MEMBER'S INFORMATION

Member's Last Name	First Name	MI	LRFA, Inc. Member#
Member's Address			
Member's Address Line 2			
Phone		E-mail	

VISITOR'S INFORMATION

Visitor's Last Name	First Name	MI	Date of Birth
Visitor's Address in Home Country			
Arrival Date in USA (MM/DD/YY)	Passport #	Country of Issue	
Beneficiary		Relationship	

COVERAGE DATES & PLAN

EFFECTIVE DATE	Month / Day / Year	Effective date will be the latest of: 1) date of arrival, 2) date requested or 3) date application and premium are received.
DEPARTURE DATE	Month / Day / Year	
PERIOD OF COVERAGE	Months	Coverage automatically terminates when covered person departs the United States.

PLEASE SELECT COVERAGE PLAN:

Benefit Plan A **Benefit Plan B**

PAYMENT FOR COVERAGE DUE

	NAME	AGE	MONTHLY PREMIUM				
Covered Person			\$	<div style="border: 1px solid black; padding: 5px;"> <p>A month begins on the effective date of coverage and terminates on the same date of following month.</p> <p>EXAMPLE: April 9 to May 8 = 1 month April 9 to May 9 = 2 months</p> </div>			
Dependent Child			\$				
Dependent Child			\$				
Dependent Child			\$				
Dependent Child			\$				
Total Monthly Payment			\$	X		=	\$

SIGNATURE

I agree to all the terms of the LRFA Emergency Accident & Health Benefit Plan for Visitors From Abroad. I understand that this is not a general health insurance, and that it is intended for use in the event of a sudden and unexpected sickness or accident. I understand that pre-existing conditions are not covered. I will inform the covered person of these terms.

LRFA Member's Signature _____ Date _____