



**LRFA EMERGENCY ACCIDENT & HEALTH BENEFIT PLAN FOR VISITORS FROM ABROAD**

# **Benefit Request**

1. LRFA Member's Last name First name MI LRFA Membership #

2. LRFA Member's address Phone  
 Male  Female

3. Person's requesting benefits Last Name First Name MI Date of birth (mm/dd/yyyy) Sex

4. Certificate # Coverage Effective date (mm/dd/yyyy) Termination date (mm/dd/yyyy)

5. Date of arrival in US (mm/dd/yyyy) Date scheduled to return to Home Country (mm/dd/yyyy)

6. Covered Person's address in Home Country

7. If accident, provide details how, when and where accident occurred

8. If illness, advise when & where symptoms first occurred and nature of illness

9. Name and address of consulting physicians  
 YES  NO

10. Have you ever been treated for this illness before? If yes, when?

11. Provide name, address and phone of your regular physician in your Home Country

12. Please provide names of any prescription medications you are presently taking

13. Other Health Insurance coverage: include name, address, policy number of Insurer

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, government agency, group policy holder, insurance company, association, employer or benefit plan administrator furnish to the LRFA or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of this benefit request and copies of all of that person's hospital and medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the LRFA Emergency Accident & Health Benefit plan for Visitors from Abroad. I authorize the group policyholder, employer or benefit plan administrator to provide the LRFA with financial and employment-related information. I understand that this authorization is valid for the term of coverage of this Benefit plan and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

\_\_\_\_\_  
 Signature of person requesting benefits or parent, if this person is a minor

I hereby certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
 Signature of person requesting benefits

## **BENEFIT REQUEST PROCEDURE**

### **Medical Expenses**

1. Form must be completed by the covered person in full and submitted along with fully itemized bills including: Person's requesting benefits name, nature of illness/injury, description and charge for each service provided.
2. This form must be signed and dated in all applicable sections.
3. Covered persons, who have other health care insurance, must submit a copy of the explanation of benefits from their other insurance company in order for benefits to be calculated.
4. Requests for benefit payments for treatments with dates of service of more than one (1) year will be rejected.

### **Accidental Death & Dismemberment**

1. Form must be completed in full by the covered person.
2. Written notice must be given to LRFA within 30 days after a covered loss occurs or as soon as reasonably possible. Notice should include LRFA Member's name, Membership No., address, Covered person's name and address in Home Country and Certificate No.
3. Written Proof of Loss must be furnished to LRFA office within 90 days after the date of loss. Requests for benefit payments submitted more than one (1) year after the date of loss will be rejected.

The deliberate of false information in benefit requests will result in the refusal of benefit or the dismissal from enrollment in the LRFA Emergency Accident & Health Benefit Plan for Visitors from Abroad.

THIS FORM AND ALL ATTACHED DOCUMENTS MUST BE SUBMITTED TO:

**LATVIAN RELIEF FUND OF AMERICA, INC.**

P.O. Box 8857

Elkins Park, PA 19027-0857