LATVIAN RELIEF FUND OF AMERICA, INC.
P.O. Box 8857 Elkins Park, PA 19027-0857
Phone: 215-635-4137 Fax: 215-635-1583

LRFA International Travel Plan
Benefit Request

1. Covered person's Last name | First name | MI

2. LRFA Membership # | **3.** Certificate #

4. Address

5. Phone | E-mail

6. Person's requesting benefits: Last name | First name | MI | Date of birth (mm/dd/yyyy) | Gender ☐Male ☐Female

7. Coverage Effective date (mm/dd/yyyy) | Termination date | Date of arrival in Home Country (mm/dd/yyyy)

8. If accident provide details: how, when and where accident occurred

9. If illness advise: when and where symptoms first occurred, nature of illness

10. Name and address of consulting physicians

11. Have you ever been treated for this illness before? ☐YES ☐NO | If yes, when?

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

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

14. 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. 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 herby certify that the above information is true and correct to the best of my knowledge.

Signature of person requesting benefits

PLEASE READ THE INFORMATION ABOUT BENEFIT REQUESTS ON THE OTHER SIDE ⇨

BENEFIT REQUEST PROCEDURE

Medical Expenses

1. Form must be completed by the covered person or guardian in full and submitted along with fully itemized bills including: Person's name requesting benefits, nature of illness/injury, detailed explanation of accident.
2. Charge and description in English or Latvian for each service provided.
3. This form must be signed and dated in all applicable sections.
4. Covered person, who has other health care insurance, must submit a copy of the explanation of benefits from his/ her other insurance company in order for benefits to be calculated.
5. Requests for benefit payments for treatments with dates of service of more than six (6) months will be rejected.

Accidental Dismemberment

1. Form must be completed in full by the covered person or guardian.
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 covered person's name and address in Home Country and Certificate number.
3. Written Proof of Loss must be furnished to LRFA within 90 days after the date of loss. Requests for benefit payments submitted more than six (6) months after the date of loss will be rejected.

Giving deliberate false information in benefit requests will result in the refusal of benefits and/or the dismissal from enrollment in the LRFA International Travel Plan.

THIS FORM AND ALL ATTACHED DOCUMENTS MUST BE SUBMITED TO:

LATVIAN RELIEF FUND OF AMERICA, INC.
P.O. Box 8857
Elkins Park, PA 19027-0857