



**LATVIAN RELIEF FUND OF AMERICA, INC.**  
 PO Box 8857 • Elkins Park, PA 19027 • Tel. 215-635-4137 • Fax 215-635-1583 • E-mail: alpf@comcast.net

# Supplemental Health Care Benefit Plan Application

**For LRFA use only:**  
 Member Number:  
 Effective date:  
 Transferred  18 years of age.

**PERSONAL INFORMATION**

		<input type="checkbox"/> male <input type="checkbox"/> female
Last name	First Name #	Sex
Date and place of birth	Member Nr.	- -
Occupation	Social Security number	
Mailing Address		
Mailing Address		
Telephone Nr.	E-mail	

**COVERAGE**

The Supplemental Health Care Plan provides monetary compensation for each day of hospital stay, regardless of any other health coverage the individual may have. Please read our brochure for more complete information.

Please enroll me in the Supplemental Health Benefit Plan group(s) checked below.

Please transfer me from my current Supplemental Health Benefit Plan group(s) to the benefit plan checked below.

group I    group II    group III    Spec. A group    Spec. B group

**Please note following diseases or health problems you have experienced in the last 3 years:**

1. Coronary heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Nervous system ailments <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Stomach or intestinal ailments <input type="checkbox"/> Yes <input type="checkbox"/> No	8. AIDS (HIV) <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Liver or gall bladder ailments <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Venereal disease <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Any accidental injuries resulting in further health ailments. <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Other ailments or operations <input type="checkbox"/> Yes <input type="checkbox"/> No

*If "yes" please explain:*

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE**

I certify that I do not have tuberculosis, cancer, AIDS or any other serious illness. I am fully aware of the regulations of the LRFA Supplemental Health Benefit Plan and information provided is true, accurate and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_