



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

This area for LRFA office use only	
LRFA Member #	
Effective Date	
Waiting Period	

PERSONAL INFORMATION		
Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date and Place of Birth	LRFA Member Nr.	Gender
Social Security Number		
Mailing Address		
Mailing Address		
Telephone Nr.	E-mail	
Please indicate any major medical conditions you have experienced:		
AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No CANCER <input type="checkbox"/> Yes <input type="checkbox"/> No LEUKEMIA <input type="checkbox"/> Yes <input type="checkbox"/> No PARALYSIS <input type="checkbox"/> Yes <input type="checkbox"/> No		
HODGKIN'S DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No TUBERCULOSIS <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER <input type="checkbox"/> Yes* <input type="checkbox"/> No *PLEASE SPECIFY: _____		

COVERAGE	
<i>The Supplemental Health Care Plan provides monetary compensation for each day of a hospital stay, regardless of any other health coverage the individual may have. Please read the regulations for more complete information.</i>	
<input type="checkbox"/> Please enroll me in the Supplemental Health Benefit Plan's group(s) checked below:	<input type="checkbox"/> Please transfer me from my current Supplemental Health Benefit Plan's group(s) to the benefit plan checked below:
<input type="checkbox"/> group I <input type="checkbox"/> group II <input type="checkbox"/> group III	<input type="checkbox"/> Spec. A group <input type="checkbox"/> Spec. B group
Coverage to begin on the 1st of _____ (month).	

SIGNATURE	
I am fully aware of the regulations for the LRFA Supplemental Health Care Benefit Plan and the information I have provided is accurate and complete.	
Signature	Date