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

PRESCRIPTION DRUG PLAN APPLICATION

This area for LRFA office use only

LRFA Member #

Effective Date

Waiting Period

PERSONAL INFORMATION

☐ Male ☐ Female

Last Name **First Name** **Gender**

#

Date and Place of Birth **LRFA Member Nr.**

- -

Social Security Number

Address

Address

Address

Telephone Nr. **E-mail**

Other Health and Prescription drug plans you participate in (other than LRFA plans)

COVERAGE

☐ Please enroll me in the Latvian Relief Fund of America, Inc. **Prescription Drug Plan.**

My age group is: ☐ 18-50 ☐ 51 up to 65

☐ I participate in the LRFA Health Care Benefit Plan

Coverage to begin on the 1st of ________________________ (month).

SIGNATURE

I am fully aware of the regulations of the LRFA Prescription Drug Plan and the information I have provided is accurate and complete.

Signature **Date**

F-50
1/2009