LRFA
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FOR LRFA OFFICE USE ONLY

LRFA Member #

Effective Date:

Waiting Period:

MEDICARE SUPPLEMENTAL PLAN APPLICATION

PERSONAL INFORMATION

Last Name	First Name	LRFA Member #
☐ Male ☐ Female		- -
Gender	**Date of Birth**	**Medicare Number**

Address

City	State	Zip

Phone	E-mail
Emergency Contact	**Relationship**
Contact Phone Number	**Contact E-mail**

COVERAGE

☐ Please enroll me in the following Medicare Supplemental Plan or Plans:

☐ Please transfer me from my current Medicare Supplemental Plan or Plans to the following:

☐ **M-Basic**	☐ **M-1**	☐ **M-2**	☐ **M-3**
☐ **M-4**	☐ **M-5**	☐ **M-6**	☐ **M-7**

Coverage to begin on the 1st of ______________________________.
Month

☐ ***I have attached a copy of the front and back of my Medicare card (required)***

Persons who are on Medicare Advantage, MEDICAID, disability or other government medical assistance programs are not eligible to enroll in the LRFA Medicare Supplemental Plans.

SIGNATURE

I agree to all terms of the LRFA Medicare Supplemental Plan and the information I have provided is accurate and complete.

Signature	Date