



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

MEDICARE SUPPLEMENTAL PLAN APPLICATION

This area for LRFA office use only

LRFA Member #

Effective Date

Waiting Period

PERSONAL INFORMATION

			<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name		Gender
		#	
Date and Place of Birth		LRFA Member Nr.	
-	-		
Medicare Nr.			
Address			
Address			
Address			
Telephone Nr.		E-mail	

COVERAGE

<input type="checkbox"/> Please enroll me in the following Medicare Supplemental Plan or Plans:	<input type="checkbox"/> Please transfer me from my current Medicare Supplemental Plan or Plans to the following:		
<input type="checkbox"/> M-Basic	<input type="checkbox"/> M-1	<input type="checkbox"/> M-2	
<input type="checkbox"/> M-3	<input type="checkbox"/> M-3D	<input type="checkbox"/> M-4	<input type="checkbox"/> M-4D
Coverage to begin on the 1st of _____.			
Month			

SIGNATURE

Persons, who have MEDICAID (Medicare Assistance for Aged) are not eligible to enroll in the LRFA Medicare Supplemental Plan.

I am fully aware of the regulations of the LRFA Medicare Supplemental Plan and information provided is accurate and complete.

Signature	Date
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