LRFA
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FOR LRFA OFFICE USE ONLY
LRFA Member #
Effective Date:
Waiting Period:

HEALTH SUPPLEMENTAL PLAN APPLICATION

PERSONAL INFORMATION

Last Name | First Name | LRFA Member #

☐ Male ☐ Female
Gender | Date of Birth

Address

City | State | Zip

Phone | E-mail

Children's Names and Dates of Birth (if adding dependents to your plan)

Name & Phone Number of Primary Care Provider (PCP)

Are you currently pregnant? ☐Yes ☐No

Please indicate any major medical conditions you have or have experienced:

AIDS	☐Yes	☐No	Heart Attack	☐Yes	☐No	Muscular Dystrophy	☐Yes	☐No
ALS	☐Yes	☐No	Stroke	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No
Cancer	☐Yes	☐No	COVID-19	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Other:	☐Yes	☐No	If “Yes” Please Specify:					

COVERAGE

H1* ☐ **20%** ☐ **50%** ☐ **80%**

H2 ☐ **50%** ☐ **80%**

H3 ☐ **20%** ☐ **50%** ☐ **80%**

☐ **Yes!** Please add my children to the above selected Health Plan (list names and ages above)

☐ ***H1**: *I have attached a copy of my primary health insurance card (required)*

SIGNATURE

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

Signature | Date