



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

Health Care Benefit 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 _____

Mailing Address _____

Mailing Address _____

Telephone Nr. _____ E-mail _____

Children's Names and Dates of Birth (if choosing option "with children") _____

Please indicate any major medical conditions you have experienced:
 AIDS Yes No CANCER Yes No LEUKEMIA Yes No PARALYSIS Yes No
 HODGKIN'S DISEASE Yes No TUBERCULOSIS Yes No
 OTHER Yes* No *PLEASE SPECIFY: _____

COVERAGE

Please enroll me in the following Health Care Benefit Plan: Please transfer me from my current Health Care Benefit Plan to the following:

Coverage with children without children

Plan A:	<input type="checkbox"/> 20%	Plan B:	<input type="checkbox"/> 20%	Plan C:	<input type="checkbox"/> 20%
	<input type="checkbox"/> 50%		<input type="checkbox"/> 50%		<input type="checkbox"/> 50%
	<input type="checkbox"/> 80%		<input type="checkbox"/> 80%		<input type="checkbox"/> 80%

Coverage to begin on the 1st of _____ Month

SIGNATURE

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

Signature _____ Date _____