



LRFA

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FOR LRFA OFFICE USE ONLY

Effective Date:

Cert.#

LRFA MEMBER'S INFORMATION

		#
Member's Last Name	First Name	LRFA Member
Member's Address		
City	State	Zip
Phone	E-mail	

COVERED PERSON'S INFORMATION

Visitor's Last Name	First Name	Date of Birth
Visitor's Address in Home Country		
Arrival Date in USA (MM/DD/YY)	Passport #	Country of Issue
Beneficiary	Relationship	

COVERAGE DATES AND PLAN

EFFECTIVE DATE	Month / Day / Year	Effective date will be the latest of: 1) date of arrival, 2) date requested or 3) date application and premium are received.
DEPARTURE DATE	Month / Day / Year	
PERIOD OF COVERAGE	Months	Coverage automatically terminates when covered person departs the United States.

PLEASE SELECT COVERAGE PLAN:

☐ Benefit Plan A ☐ Benefit Plan B

PAYMENT FOR COVERAGE DUE

NAME	AGE	MONTHLY PREMIUM			
Covered Person		\$	Payments are calculated on a 30 day basis.		
Dependent Child		\$			
Dependent Child		\$			
Dependent Child		\$			
Total Monthly Payment		\$	X	NUMBER OF 30 DAY PERIODS	TOTAL
			=	\$	

SIGNATURE

I agree to all terms of the LRFA Medical Plan for Visitors From Abroad and the information I have provided is accurate and complete. I understand that this is not general health insurance, and that it is intended for use in the event of a sudden and unexpected sickness or accident.

Signature

Date

MEDICAL PLAN FOR VISITORS FROM ABROAD