LRFA

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FOR LRFA OFFICE USE ONLY

Effective Date:

Cert.#

TRAVEL MEDICAL PLAN APPLICATION

LRFA MEMBER'S INFORMATION

		#
Member's Last Name	**First Name**	**LRFA Member**
Passport Number	**Name & Phone Number of Primary Care Provider (PCP)**	
Member's Address		
City	**State**	**Zip**
Phone	**E-mail**	
Beneficiary	**Relationship**	

COVERAGE DATES & PLAN

DESTINATION

EFFECTIVE DATE ___/___/___ Month Day Year

RETURN DATE ___/___/___ Month Day Year

PERIOD OF COVERAGE ____ days

Effective date will be the latest of: 1) date of departure, 2) date requested, or 3) date application and premium are received.

Coverage automatically terminates when covered person returns to the Home Country.

PLEASE SELECT COVERAGE PLAN:
☐ **Benefit Plan A** ☐ **Benefit Plan B**

PAYMENT FOR COVERAGE DUE

Maximum period of coverage is eight (8) months

	Name	Date of Birth	Age	# of Days	Payment
Covered Person					
Dependent Child					
Dependent Child					
				Total Payment:	

EXAMPLES:
For 01 to 15 day travel - 15 day rate applies
For 16 to 30 day travel - 30 day rate applies
For 31 to 45 day travel - 15 day rate + 30 day rate applies
For 46 to 60 day travel - 2 x 30 day rate applies
(include both the departure and return dates in your total day count)

SIGNATURE

I agree to all terms of the LRFA Travel Medical Plan 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**