LRFA

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FOR LRFA OFFICE USE ONLY

LRFA Member #

Effective Date:

Waiting Period:

MEDICARE SUPPLEMENTAL PLAN APPLICATION

ENROLLMENT MADE EASY

- **Already a LRFA Member?**
  Simply complete this form and return it with payment.
  Thank you for your membership!
- **Enroll online: www.LRFA.org**
- **Not a LRFA Member?**
  Complete this form and include an additional $50 membership payment.

PERSONAL INFORMATION

Last Name	First Name	LRFA Member #
☐ Male ☐ Female	-	-
Gender	**Date of Birth**	**Medicare Number**
Address		
City	**State**	**Zip**
Phone	**E-mail**	

COVERAGE

☐ **Enroll** me in the following plan/s:
☐ **Transfer** me from my current plan/s to the following plan/s:
☐ **Add** the following plan/s to my current plan:

☐ **M-Basic** ($126/mth) ☐ **M-1** ($225/mth) ☐ **M-2** ($64/mth) ☐ **M-3** ($130/mth)

☐ **M-4** ($395/mth) ☐ **M-5** ($90/mth) ☐ **M-6** ($101/mth) ☐ **M-7** ($195/mth)

Coverage to begin on the 1st of _____
Month

Persons who are on MEDICAID, disability or other government medical assistance programs are not eligible to enroll in the LRFA Medicare Supplemental Plans.

PAYMENT

Amount $_____ ☐ **Check made out to LRFA enclosed**

Credit Card (online fee applies): ☐ **Visa** ☐ **Mastercard** ☐ **AmEx** ☐ **Discover**

Card Number: _____ **Exp:** _____ **CVV:** _____

☐ **Same as above**

Cardholder Name _____

Cardholder Address _____

SIGNATURE

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

Signature **Date**