



# LRFA

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## FOR LRFA OFFICE USE ONLY

LRFA Member #

Effective Date:

Waiting Period:

# HOSPITAL SUPPLEMENTAL PLAN APPLICATION

### PERSONAL INFORMATION

		#
<b>Last Name</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>First Name</b>	<b>LRFA Member</b>
<b>Gender</b>	<b>Date of Birth</b>	
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Phone</b>	<b>E-mail</b>	
<b>Name &amp; Phone Number of Primary Care Provider (PCP)</b>		
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Please indicate any major medical conditions you have or have experienced:</b>		
AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy <input type="checkbox"/> Yes <input type="checkbox"/> No
ALS <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes" Please Specify: _____		

### COVERAGE

*The Hospital Supplemental Plan provides monetary compensation for each day of a hospital stay, regardless of any other health coverage the individual may have. Please read the regulations for more complete information.*

Please  enroll me in    OR     transfer me to  
the Hospital Supplemental Plan checked below:

Group I     Group II     Group III     Spec Group A     Spec Group B

### SIGNATURE

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

Signature

Date