APPLICATION FOR MEDICAL ASSISTANCE

Date : _____ **Application Number : _____**

Membership No : _____ **Category : Regular _____**

The Trustees / Committee Members
Shri J. H. V. S. Jain Charitable Trust / Gnati (Mumbai)
Mumbai.

Dear Sir,

Ref :Medical Assistance for Rs _ _ _ _ _ _ _ _ _ _ _ _ _
Member Full Name : _____

I request you to grant my _____ (**Relation : Self / Wife / Son / Daughter etc)** aged _____ Years

Medical assistance to wards reimbursement of _____
(Specify : Medical Bills / Hospitalization etc)

The details of the Applicant are as under

1. Applicant Full Name **:** _____

2. Address of Member **:** _____

_____

3. Contact Number **:** **Cell : _____ Landline : _____**

4. Nature of Sickness / Ailment **:** _____

_____

5. Brief Medical History if any **:** _____

_____

6. Mediclaim Policy Status **:** **Insured ◯ / Non – Insured ◯ (Attach relevant Policy Copy)**

The details of expense incurred is as under

Sr	Payment Details	Receipt No.	Date	Amount
1				
2				
3				
4				
	Total			

Thanking you,

Yours truly,

_____

(Member's Signature)

(For Office Use Only)

Application considered in Managing Committee Meeting held on

(Authorised Signatory) **(Treasurer)**

Note : All information sought is mandatory and incomplete application may get rejected