APPLICATION FOR MEDICLAIM PREMIUM

Date : _____ **Application Number : _____**

Membership No : _____

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

Dear Sir,

Ref :Mediclaim Premium Assistance for Rs _ _ _ _ _ _ _ _ _ _ _ _ _

Member Full Name : _____

I request you to reimburse my Mediclaim Premium amount as per details hereunder

1. **Applicant Full Name** : **_____**
2. **Address of Member** : **_____**
   _____
3. **Contact Number** : **Cell : _____ Landline : _____**
4. **Mediclaim Policy Details** : **Policy Issued By _____**
   Insured Amount Rs _____
   Yearly Premium Rs _____
   Receipt Number & Date _____
   (Attach relevant Policy Copy)

The details of family members insured are as under

Sr No	Family Member Details		Sum Insured	Premium Amount
	Name	Age / Sex		
1				
2				
3				
4				
5				
6				
	Grand Total			

Thanking you,

Yours truly,

_____

(Member's Signature)

(For Office Use Only)

Application considered in Committee Meeting held on _____

(Authorised Signatory) **(Treasurer)**

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