Gowd Saraswat Brahman Sabha, Mumbai
101, Sreenidhi, 76, Bhau Daji Road, Opp. Bank of Baroda,
Matunga (C. R.), Mumbai – 400 019

APPLICATION FORM FOR MEDICAL AID FUND

Form no. MAF. 1 / 2015

PHOTO

To,

The Managing Committee,
Gowd Saraswat Brahman Sabha, Mumbai,
101, Sreenidhi, 76, Bhau Daji Road,
Opp. Bank of Baroda, Matunga (C.R.),
Mumbai 400 019

Name : _____ **DOB :** _____

I hereby apply for assistance under the Medical Aid Fund Scheme of the Sabha and for this purpose, I furnish the following particulars:-

1) Name of the Applicant :

First Name	Middle Name	Surname	Sex	Age
			F/ M	

Occupation : _____ at _____ since _____years

2) Residential Address : _____

_____ Pin : _____

Contact No: Landline : _____ Mobile : _____ Email Id : _____

Alternative Contact No: Landline : _____ Mobile : _____

Name & address of that person : _____

_____

3) Name of the Patient :
(If differs from applicant)

Relationship with Applicant: **:** _____ **Age :** _____**Years**

4) Total family members living in the house : _____

Total Annual Income of the family :
(*Please fill all details in the following table pertaining to all family members living in the same dwelling)*

Name	Relationship with the applicant	Occupation	Gross Annual income (Rs.)
1	**Self**		
2			
3			
4			
5			
6			
		Total annual income of the family (Rs.)	

5) Medical history :

Nature of illness / Ailment : _____

Name & Address of Doctor / Hospital
From where treatment is taken : _____

_____

Whether prescription / bills enclosed ? Yes / No

Total Expenses incurred : _____

6) Benefit (s) availed from this Sabha earlier or from any other source (s) : Yes / No (please *tick* ✓*whichever is applicable*)

If Yes, please mention the details of the same :

Name of the Institution / Individual : _____ Amount (Rs.) _____ When received : _____

DECLARATION

The above information is true to the best of my knowledge and if the same is found to be false, I will, on demand by the Sabha, return the relief granted to me. Kindly grant me assistance under Sabha's Medical Aid Scheme. Please attach a cancelled cheque if reimbursement through a bank transfer is acceptable.

Signature of the applicant

1. Proposed / Recommended by :

Name : Age : Tel / mobile no. :

Address :

Whether member of GSB Sabha: Yes / No

Since how long you know the applicant / patient ?

Recommendations:

Signature of the Proposer

2. Proposed / Recommended by :

Name : Age : Tel / mobile no. :

Address :

Whether member of GSB Sabha: Yes / No

Since how long you know the applicant / patient ?

Recommendations:

Signature of the Proposer

Inward No. **FOR OFFICE USE ONLY** **Application Received on :** _____

Being eligible under Medical Aid Fund Scheme as per scrutiny, we recommend the above case for assistance of under captioned Scheme.

Scrutinized by : Name: _____ **Decision of the Managing Committee held on :** _____

Observation / Recommendations:

Signature ::_____ Date: _____ Signature ::_____ Date: _____