ESTD. 1987

GHOGHARI LOHANA MAHAJAN CHARITABLE TRUST

(PUBLIC TRUST REG. NO. E11486-BOMBAY)

Lohana Bhuvan, Paliram Road, Andheri (West), Mumbai - 400 058.

Phone : 022-2628 37 15 • Email : secretary@sglm.in • Website : www.sglm.in

INTEGRITY I INTELLECT I TRANSPARENCY

MEDICINE AID FORM

Form No. : _____

Membership No. : _____ KYM No.: _____

Applicants Details :

First Name : _____ Middle Name : _____ Surname : _____

Date of Birth : _____ Age : _____ Gender : _____

Residence Address : _____

_____

Telephone No. : _____ Mobile No. : _____

Email ID (Self / Family Member) : _____

Occupation (Self Employed / Business / Employee) : _____

Occupation Address : _____

Telephone No. : _____ Mobile No. : _____ E-mail Id : _____

Family Details :

Total No. of Members in the family : _____ Total Earning Members in the Family : _____

Total Monthly income of Family (INR) : _____

S. No.	FULL NAME	AGE	OCCUPATION	MONTHLY INCOME	RELATIONSHIP
1.					
2.					
3.					
4.					
5.					
6.					

Are you or your family recipients of any other form of aid from SGLM? (Financial/ Medical/ Education/Food Distribution). (Please tick whichever applicable)

Have you taken any financial aid from any other trust or person for the current illness ? Y / N

Please mention amount (INR) _____& name of the Trust or person from which aid is availed _____

_____ Telephone / mobile number of the trust and Contact person : _____

Do you have mediclaim policy ? Y / N _____ If yes, what is the cover amount of your individual or family policy.

Are you interested in part paying for a mediclaim policy through Mahajanshree : Y / N

Reference from any 1 community / committee Member.

I the undersigned hereby certify that I know the applicant for _____ years and that the above and enclosed information is accurate to the best of my knowledge. I further certify that he/she is eligible the aforesaid grant.

Name : _____ Signature : _____

Telephone / Mobile : _____ Membership Number if known : _____

Part II

Do you suffer from any of the following :

Diabetes	: Y / N	Blood Pressure	: Y / N
Kidney Disease	: Y / N	Thyroid	: Y / N
Heart Disease	: Y / N	Otherdieses	: Y / N

Please mention any other ongoing illness that you suffer for which continuous & ongoing medical is required.

_____

Name of the Treating Doctor : _____

Address : _____ Telephone No : _____

Where was the Treatment Availed : _____ Private Consultation / Trust / Government Hospital

Date of Visit : _____

Signature & Stamp of the Treating Doctor : _____

Please attach the following with your application (in originals) failing which the applicant may not be get due consideration

Medical enclosures

- Original Doctors Consultation Prescriptions.
- Please ensure that period of treatment is mentioned on the prescription, failling which appropriate medicines may not be disbursed.

Please note the following

- We will not be granting Over the Counter (OTC) medicines eg. Calcium, Multivitamins, Pain balms, Protein, Electoral Powders, unless the treatment demands its need.
- The disbursal limit is INR 1000/- per month / person.
- The final approving & disbursal authority remains with the medical committee / office bearers of the Mahajanshree.
- The above information is collected solely with a purpose to provide aid & benefits to the applicant member.
- You can courier the duly completed form with attachments at the address mentioned above or email them to secretary@sglm.in

Name : _____ Relationship : _____

Signature : _____ Date: _____

For SGLM office use only

Received on date & by : _____ Reviewed on : _____ Reviewed by : _____

Sanctioned Amount : _____ Sanctioned by : _____

Signature (1) _____ Signature (2) _____