Sir Ness Wadia Foundation

Neville House, J. N. Heredia Marg, Ballard Estate, Mumbai 400 001

APPLICATION FORM FOR MEDICAL AID

Form given on ---------- Form received on ----------

1. Name of the Applicant: ----------
2. Name of the Patient : ----------
3. Relationship with the Patient : ----------
4. Age of the Patient : ----------
5. Local Address : ----------
6. Permanent Address: ----------
7. Contact No : ----------
8. Family Data :

Name	**Relationship**	**Occupation**	**Income**

9. Name of the Aliment /Disease/Injury: ----------
10. Name & Address of the Hospital where treated /to be treated:----------
11. Registration No. of the Hospital: ----------
12. Name & Qualification of the Treating Doctor : ----------
13. Registration No. of the treating Doctor : ----------
14. Date of Admission: ---------- Date of Discharge : ----------
15. Approx. expenses for treatment : ----------
16. Financial assistance sought from other Trust :

Name of the Trust	Amount Received / Promised

17. Amount received/receivable under Mediclaim ,if any: ----------
18. Amount received/receivable from Employer, if any: ----------
19. Family's contribution : ----------

20. Financial assistance received from Sir Ness Wadia Foundation in past

Amount	Date

21. Signature if the applicant : ----------

22. Certified the above facts to be true : ----------

(Signature of person certifying – Doctor /known Personality)

23. Documents required (Please tick against documents being provided)

Proof of Residence ie Ration Card		Hospital /Medical bills	
Income Certificate		Doctor's Certificate /statement for estimated cost of treatment	
Doctor's Certificate		Recommendation letter	

NB: Incomplete forms without proper documents will not be accepted /considered by the Trust office

Date:

Time:

RECOMMENDED: AMOUNT (Rs.) ----------BY: ----------

(CHIEF ADMINISTRATOR)

APPROVED BY: ---------- ----------

(TRUSTEE) (TRUSTEE)

UNDERTAKING

(In case Medical Relief is sought in advance for specified treatment)

In case of receiving monetary assistance from the Foundation in advance for specified treatment, I hereby give a guarantee that in case the specified treatment is not being undertaken I will return the money so received within 7 days from knowledge of the fact that the specified treatment is not being undertaken.

I solemnly declare that the information stated in this application form is true and correct.

Date: ----------

SIGNATURE OF THE APPLICANT

SIGNATURE OF WITNESS

DECLARATION

(Applicable for medical assistance to existing employees of Wadia Group establishments)

I, Mr. / Mrs. (Name of the employee) …….. …….. Employee No. …….. Of (Name of the establishment) …….. Hereby declare that my medical entitlement for the year ……has been fully utilized.

Date:

SIGNATURE OF THE EMPLOYEE

SIGNATURE OF THE CEO OF THE DIVISION

SIGNATURE OF THE COMPANY DOCTOR