Y.C.Z.A. EDUCATIONAL ULARFFABLE FUND

Address: C/o SORABJI EDUUI DAVAR TRUST FUND,
18, SIR H.C. DINSHAW BUILDING,
HORNIMAN CIRCLE, FORT, MUMBAI 400001.
TEL: 022-22665562
Email id: sorabjieduijidevartrusdund@gmail.com

TRUSTEES:

1) Mr. Nadir Modi (Chairman)
2) Mr. Kersi Commissariat
3) Dr. Nozer Sheriar
4) Mrs. Nawaz Modi Singhania
5) Mr. Saroosh Dinshaw
6) Mrs. Farzana Doctor
7) Mrs. Beroz Kumie Gazdar

Space for Trust Office use only:	
For Trustees' use only	*Called on ________ at ____ p.m. /a.m.*
Rejected /Approved	*Sanctioned Rs.____________________*
Signature :__________________	__________________

Photo

INSTRUCTIONS FOR APPLICANTS SEEKING MEDICAL HELP:

a) Forms not completely / correctly filled in, may not be considered.
b) Please submit salary / income certificates of the applicant and family.
c) Reimbursement will only be made against proof of payment of medical bills.
d) Original bills and receipts required for verification and record.
e) Only the applicant or close relative to submit the Form, along with all necessary documents.

DATE:____________________

1) NAME OF THE PATIENT: _________________________________

2) NAME OF THE APPLICANT: _________________________________

3) ADDRESS OF THE PATIENT: _________________________________

____

4) TEL. NO:_____________________ E-MAIL ID:_________________________________

5) AADHAR CARD NO. OR PAN CARD NO:______________________ (ATTACH SIGNED COPY)

6) NATURE OF ILLNESS AS DIAGNOSED: _______________________________

7) LETTER / CERTIFICATE FROM ATTENDING DOCTOR _______________________________

8) IF HOSPITALIZED — NAME AND ADDRESS OF THE HOSPITAL AND TEL. NO______________________

____

9) TOTAL HOSPITALIZATION COST: Rs ______________________
(MEDICAL BILLS WITH DOCTOR'S PRESCRIPTIONS TO BE ATTACHED, ALONG WITH DISCHARGE CARD. APPROPRIATE ORIGINAL BILLS WILL BE VERIFIED & MAINTAINED ON OUR RECORD)

10) IF NOT HOSPITALIZED PLEASE STATE:

A. NATURE OF ILLNESS AND ATTACH LETTER FROM ATTENDING DOCTOR:____________________
B. APPROXIMATE COST FOR ENTIRE TREATMENT: Rs.____________________________
C. ATTACH: BILLS FOR CONSULTING FEES / CHEMIST BILLS, ALONG WITH DOCTOR'S PRESCRIPTIONS.

11) DEPENDENT MEMBERS IN THE FAMILY (STATE NAMES, AGE, RELATIONSHIP & INCOME) :

____

____

____

12) STATE PARTICULARS OF HELP IF RECEIVED / EXPECTED FROM OTHER SOURCES:

a)		Rs.____________________
b)		Rs.____________________
c)		Rs.____________________
	Total	Rs.____________________

SIGNATURE OF PATIENT: SIGNATURE OF APPLICANT (IF OTHER THAN PATIENT):

____________________ __________________________

RECOMMENDATION: THIS APPLICANT IS WELL KNOW TO ME

NAME OF RECOMMENDER:____

ADDRESS OF OFFICE / RESIDENCE AND TEL NO.:

____

____

STAMP / SIGNATURE OF RECOMMENDER:____