Indian Film & Television Directors' Association

Tel: 022-65164283/ 26733197 Email: iftdaindia@gmail.com Website: www.iftda.co.in

Date : _____

APPLICATION FORM FOR MEDICAL AID

1. Name of the Member: _____
   (in block letters)

2. Address : _____

   (in block letters) _____

   _____

   _____

   Contact Nos. : _____

3. Sex and Age : _____

4. Membership Details

   (i) Category : _____ (ii) Membership No. : _____

   (iii) Enrolled on: _____ (iv) Subscription paid upto: _____

5. Total Monthly Income of the
   Applicant & his / her family : _____

6. Nature of Disease _____

   _____

   _____

   _____

   _____

7. (i) Name of the Doctor / Hospital/ Nursing Home _____

(ii) Address & Contact Nos. _____

_____

8. When to start treatment / operation _____

9. Amount of help at present required _____

_____

10. Amount and date of Medical help received by the Applicant from IFTDA in the past _____

_____

11. Whether Applicant is getting help from other Association / FWICE / Film Industry Welfare Trust / any other Trust or from any other source? Give details. _____

_____

12. Any other information _____

_____

Encl. : Xerox of IFTDA Membership Card
Medical Documents

_____
Signature of Member

N.B. : Only 3 years old enrolled Members eligible.

: Family Members are not covered under this Welfare Scheme.

: Incase of Emergency, this application form can be submitted on behalf of the member by his / her relative or friend.