G-8/9/10, Crescent Towers, Near Morya House, Off New Link Road, Andheri (W), Mumbai - 400 053
Tel: 022 46088096/ 9892885346/ 7021494476
Email:iftdaindia@gmail.com/contact@directorsiftda.com Website:www.directorsiftda.com

Date : _____

MEDICAL AID FORM

(Member is eligible for medical aid only after 3 years of enrollment)

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

2. Address : _____

   (in block letters) _____

   _____

3. Contact Nos./ Email : _____

4. Gender and Age : _____

5. Membership Details

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

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

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

7. Nature of illness _____

   _____

   _____

   _____

   _____

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. : 1. ***Medical help will be paid directly in the bank account of Hospital/ Nursing Home/ MBBS Doctor. The following details be given:***

- ***Name of the Beneficiary***
- ***Account Number***
- ***Bank's Name***
- ***IFSC Code***

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

3. ***Family Members are not covered under this Welfare Scheme.***