MISSIONARY UPHOLDERS TRUST

Admin Off: Civil Supplies Godown Street, Kamalatchipuram, Vellore-632 002
0416 -2260368, +91-9600989250 email: mut.vellore@gmail.com / mut.medical@gmail.com

APPLICATION FORM FOR FINANCIAL ASSISTANCE FOR MEDICAL TREATMENT
LOVE YOUR BROTHER SCHEME

Objectives:

- ***To provide medical help to the family of a member missionary.***
- ***To encourage the spirit of mutual concern and oneness among missionaries from various Missionary Organizations and enable the Missionary Community to help itself.***
- ***To provide a common platform to mobilize prayer support and comforting communications within the Missionary Fraternity for the families of the member missionary.***

Important instructions:
1) Kindly fill all the columns for quick processing.
2) Please send the application to the above address through your Organization.
3) Please fill separate forms for each person.
4) Send bills within 3 months

1. Name of Applicant…… Date of Birth:…… Age: ☐
(*As registered with IMPACT*)

Gender: Male ☐ Female ☐

Field Address:	Organization Address:
Mobile No:	Phone No:
Email ID:	Email ID:

2. IMPACT NO: SELF ☐ SPOUSE ☐
3. Have you done Master Health Checkup (MHC)? YES / NO
4. If Yes, A) Date: …….. B) Hospital: ……..
C) Findings:…….
5. Are you receiving Affordable Cost Medicine from MUT (Tick)?
A) Diabetes B) Blood Pressure C) Cholesterol
If required please contact @ mobile number: +91-9600-989-250
6. Marital Status : Married ☐ Unmarried ☐
7. Occupation of Spouse: …….
A) Monthly Income: ₹ ☐ B) Medical Allowance: ₹ ☐
8. Name for whom the help is sought(Tick): SELF ☐ WIFE ☐ HUSBAND ☐ DOB……
SON ☐ DOB…… Student / Occupation: ……
DAUGHTER ☐ DOB…… Student / Occupation: …….....

9. If unmarried DEPENDENT FATHER ☐ DEPENDENT MOTHER ☐

A) Name : B) Age:

10. Brief nature of illness:……
(Doctor's certificate / Discharge Summary MUST be attached with every application)

11. DETAILS OF EXPENSES : (Attach list of bills (Original) with date & total)

Hospital Bill :₹

Medicines :₹

Investigations :₹

TOTAL EXPENSES :₹ (Should tally with the list)

12. Financial Assistance received for this illness: (*****Mandatory to fill)

a) Organization Amount ₹…… Date……...

b) Insurance Amount ₹…… Date……...

c) Any other Amount ₹…… Date……...

13. ***Bank Account Details:**
Please attach Xerox Copy of Bank Pass Book First Page (If organizations please mention).

Signature of Applicant **Date:**

FORWARDING NOTE BY THE MISSION ORGANISATION

MUT Contribution paid up to month / year……..

Signature & Stamp of the mission organization's
Authorized Signatory with Name **Date:**

PLEASE NOTE:
(1) The members are expected to avail treatment in Mission Hospitals wherever possible. Opt for inexpensive treatment as far as possible.
(2) Categorisation and amount sanctioned is decided by the MUT medical team as per norms.

For MUT Office use only

Sanctioned by **Approved by**

Date: **Date:**