

ANKAMUTHI CHARITABLE TRUST

DISTRIBUTION APPLICATION FORM

GENERAL MEDICAL



Advancing Relief of Poverty and Advancement of Social Welfare

Provides each registered beneficiary and dependents with financial assistance towards general medical treatment and costs. Assistance is available where you are the person seeking assistance, and if you are supporting another family member seeking assistance, up to the limit of \$7,000 per financial year.

SECTION 1 - BENEFICIARY INFORMATION		
Application Date: ____/____/____	Date of Birth: ____/____/____	
Full Name:	Suffix: <input type="checkbox"/> Junior <input type="checkbox"/> Senior	
<input type="checkbox"/> If your contact details are the same , tick the box and skip to Section 2. If changed , please update below		
Street Address:		
City / Suburb:	State:	Postcode:
Email:	Phone:	
SECTION 2 – APPLICATION DETAILS		
Patient Name:		
Relationship to Applicant (eg: spouse, child):		
Appointment Date(s): ____/____/____ ____/____/____	Appointment Location(s):	
SECTION 3 - FUNDS REQUESTED – TICK BOXES OR PROVIDE NOTES		
<input type="checkbox"/> Medical Costs <input type="checkbox"/> Pharmacy Costs <input type="checkbox"/> Prescription Glasses <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Standard Doctors Appointments <input type="checkbox"/> Purchase of exercise equipment on preventative health grounds (can apply every 5 years) <input type="checkbox"/> Travel Allowance <input type="checkbox"/> Accommodation <input type="checkbox"/> Food Allowance (capped at \$500 for a 2 week period)		
* Attach a support letter from a Doctor/Hospital, appointment confirmation, quote for goods and/or services		
Notes _____		

IS THIS A REIMBURSEMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach quote/tax invoices)		
TOTAL OF CLAIM	\$	

Applications will NOT be processed until supporting documentation and supplier payment details are received.

- I am not eligible for benefits from any other funding source in relation to this account (e.g. Queensland Health, Health Insurance Provider, Medicare).
- I understand that my application will be processed by the Trustee (Mutual Trust) within **FIVE (5) business days once all required supporting documentation has been received.**

Beneficiary Signature: _____

Date: ____/____/____

Please send completed forms and supporting documents to Mutual Trust by:

Fax: (08) 9230 7701 **Email:** Ankamuthi@Mutualtrust.com.au **Mail:** Mutual Trust, PO Box 122, NEDLANDS WA 6909

If you have any queries, please contact us on (08) 9230 7744