

LPA GEORGE BOCK CHARITABLE TRUST

APPLICATION FOR FUNDS

It is the intended primary purpose of the LPA George Bock Charitable Trust (Trust) to reimburse the costs of major dwarf-related medical expenses not covered by insurance. It is not intended to cover deductibles, co-insurance fees, routine medical expenses, well baby care or accident related costs. In order to adhere to the agreement with the donor Trust, priority is placed on applications from LPA members of the Garden State Chapter and the state of New Jersey, with excess available funds granted to applicants from outside the state of New Jersey. Any remaining funds for the year are to support the adoption of short stature children where anticipated dwarfism related medical complications create a barrier to placement.

Mail the completed form and enclosures by April 1 to:

Lois Gerage-Lamb
6511 LAKE CIRCLE DR
DALLAS TX 75214-3416

If you have questions, please feel free to call Lois Gerage-Lamb, <mailto:littlelogl@aol.com> between 7:00 PM - 10:00 PM CST Monday - Friday at 214-826-6284 or e-mail her at littlelogl@aol.com

APPLICATION FOR GEORGE BOCK CHARITABLE TRUST

Please type or print in ink. Continue on separate sheet(s) of paper if necessary.

Date:	
Applicant's Name:	
Address:	City/State/Zip Code:
Home Telephone Number:	Work Telephone Number:
E-Mail address:	
Age:	If LP is under 18 yrs of age, please state relationship to applicant:
LPA Chapter	District:
Years of membership:	
Type of dwarfism:	
Brief description of dwarfism-related medical condition for which reimbursement is requested:	
Date of medical procedure for which reimbursement is requested:	
Name of doctor who treated applicant for the above-referenced condition:	
Specialization:	
Address:	City/State/Zip Code
Telephone Number:	
Doctor's comments: <i>Enclose photocopy of doctor's report.</i>	

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Name of primary medical insurance company:	
Address:	City/State/Zip Code
Telephone Number:	
Contact Person:	

Name of secondary medical insurance company:	
Address:	City/State/Zip Code
Telephone Number:	
Contact Person:	

1) Total cost of above-referenced medical procedure(s) \$ _____
(Attach copies of itemized bills and dates incurred)

2) Total amount of payment by insurance company \$ _____
(Itemize individual insurance payments, amounts, date paid)

3) Total amount of deductible paid by applicant \$ _____

4) Total amount of payments (not including deductibles) made by applicant \$ _____
(Itemize payments and date incurred)

4) Total amount requested for reimbursement \$ _____

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Describe reason given for denial or lack of insurance coverage/reimbursement. Enclose copy of notice of denial.

Describe any sources other than medical insurance company you have contacted and the results.

Describe any other assistance or support (i.e., family, church, community groups, March of Dimes, etc.

Due to limited funds, the Bock Trust may only be able to pay one bill or a portion thereof. Please prioritize the bill(s) for which you are requesting funding to be considered by this trust fund.

The gross annual income* for your household at time of medical procedure for which reimbursement is requested. \$ _____

The current annual income for your household, if different \$ _____

*To figure gross annual income, add gross annual income received from work, plus untaxed income, according to your current IRS Form 1040.

Total number of dependents in your household claimed on your current 1040. _____

Were your medical expenses for the calendar year in question more than, or equal to 7.5% of your adjusted gross income, as reflected on your 1040? _____

Is there any other information you feel LPA should know in considering your application, including extenuating circumstances?

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LPA will keep all documents submitted; please keep photocopies for your records. Your signature below demonstrates your understanding and consent that the documents submitted with this application and the information contained therein may be released to members of LPA Board of Directors, the members of LPA George Bock Charitable Trust Review Committee, and any independent medical and/or insurance professionals selected and consulted by the Committee, for assistance in interpreting medical and insurance information for the sole purpose of determining and awarding of funds.

Signature

Date