

Forest River/Thor Community Foundation, Inc.

Application

Name _____

Address _____

City, State, Zip _____

Current Employer Forest River Thor Plant/Subsidiary _____

Supervisor's Name _____

Without describing the medical condition, please describe the intended use of the funds, e.g. medical bills:

Amount requested (Maximum \$20,000): _____

If request is based on medical expenses, has claim(s) been submitted to insurance for payment?

Yes

No

If submitted, was claim denied?

Yes

No

Other sources of assistance applied for:

I have reviewed and agree to comply with the Forest River/Thor Community Foundation, Inc. guidelines. I have submitted all of my documentation. I understand that this application requires employment validation by the Forest River/Thor review Committee. I recognize that validation does not guarantee that I will receive funds. I certify that the above information is true and accurate.

Employee Signature

Date

Phone Number