Coast Guard Mutual Assistance

Medical Dental Expenses Loan

CGMA is dedicated to a policy of fair treatment. At all times, CGMA will provide an environment that promotes dignity, respect, fairness, and inclusion. These are essential ingredients to the sustainment of operational excellence, a positive office climate and a healthy work environment. All CGMA personnel and representative will comport themselves in accordance with all Coast Guard civil rights policies at all times. All CGMA clients will adhere to this policy in their interactions with CGMA HQ personnel and CGMA Representatives.

Purpose: Assistance may be provided to help with immediate needs when a client or their immediate family members are affected by a medical or dental emergency.

CGMA Client Information

Name: First	M.I	Last	Suffix	SSN last 4	Employee/Auxiliary ID

Home address: Line 1	Line 2	City	State	Zip Code	Phone #

Member Status:	Active Duty	Retired	Reserve	Civilian	Auxiliary	PHS	Other
	☐	☐	☐	☐	☐	☐	

Rank/Rate/Title	Unit	OFPAC #	Check if client is deceased
			☐

Married:	# of Dependent including spouse	Year joined CG	Year retired	Year of birth
☐ Yes ☐ No				

Email address: personal/Zelle	Email address: Work

Zelle is an electronic disbursement application between CGMA's bank and yours.

Applicant Information

To be completed if the applicant is not the CGMA Client (i.e. spouse, widow(er) or other authorized family member)

Name: First	M.I	Last	Suffix	SSN last 4	Relationship to Client	Power of Attorney
						☐ Yes ☐ No

Email address: personal/Zelle	Pre-Authorization Form	Phone #
	☐ Yes ☐ No	

Request and purpose

Type of Assistance Requested	Amount requested	Monthly Repayment	Prefer Funds:
Loan	$	$	☐ electronic disbursement ☐ Check

Reason for assistance (attach additional pages if necessary and documentation)

CGMA Client/Applicant's Certification

☐ Everything that I have stated in this application is correct to the best of my knowledge. You are authorized to check the facts surrounding this request including my credit and employment history. I understand that any misstatement of fact is grounds of denial of this request. I understand that I am responsible for any unpaid balance and that any delinquent unpaid balance may be referred to a collection agency and may affect my credit.

☐ I have attached all applicable medical or dental statement and bill.

☐ I have a statement from a doctor or other medical authority attesting that the services are medically required and essential for the health and welfare of the individual.

☐ I have attached copies of any denials or reduced benefits received from TRICARE, private insurance companies, the government, or other sources.

Client/Applicant's Signature _____ Date _____