Annexure - IV

Application for Hospitalisation under Post-Treatment Payment Facility in respect of self or member(s) of family

Staff : Supervising / Award (for 23 specified serious disease)

State Bank of India,
..... Branch
..... Office
..... Code
.....Module

Date :

Place of Posting :
.....

01. Name of Employee in full (In block letters) :

02. Designation/Grade :

03. Department/Section :

04. Name of the patient :

05. Relationship of the patient with the employee :

06. Name of the disease (supported by attending Doctors/Hospital/ N. Home Certificate) :

07. Name of the Hospital :

08. (a) Medical Expenses to be debited to (Name of the Branch/Office) :

(b) Branch/Office Code No. :

Please arrange for admission under Post-treatment Payment Facility as stated above in terms of Head Office Circular letter No.....dated .....

Dated :

(Signature of the employee)

Declaration:

I Shri/Smt. ..... hereby solemnly declare that :

i) I am not entitled to any reimbursement of contribution towards medical expenses under personal accident policy or under any claim in respect of accident from any other source.

ii) My family member(s) viz. parents, wife, son or daughter are fully dependent on me.

iii) The income of my dependent family member for whom hospitalization is required does not exceed Rs.1500/- p.m. (Rupees one thousand five hundred only) from all sources.

(Signature of employee)

Signature verified

I, the undersigned hereby certify that all the particulars furnished herein by Shri/ Smt. ..... are true to the best of our knowledge and belief.

Asst. General Manager/Chief Manager/ Manager of

.....Branch/ Department

Recommendation and stipulations:

We have examined the proposal and recommend for Post-Treatment Payment Facility in favour of Shri/Smt. .....(Name of employee) for his/her dependent family member at .... hospital (Name of Hospital). Please issue Post-treatment Payment Facility credit letter to the Hospital Authority with following stipulations:

i) No cash disbursement / reimbursement will be made by the Bank.
ii) Payment of all medical expenses will be made directly to the Hospital Authority.
iii) Office to be debited -
iv) Branch/Office Code No. -

Branch Manager/ Chief Manager/ Asst. General Manager	Asst. General Manager of the Region/Deptt.	Dy.General Manager (Module, Di[illegible]ntrol Branches/ Mid [illegible]te/ Central Office Establish-ment / CDO (for other Circle)