KERALA STATE ROAD TRANSPORT CORPORATION

FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF KSRTC EMPLOYEES AND THEIR FAMILIES

1. Name (In Block letters) & Designation of employee with PF. No. :

2. Pay & scale of Pay :

3. Office in which employed :

4. Place of duty :

5. Residential Address :

6. (i) Name of patient and relationship of the employee to the patient :

   (ii) If the patient is spouse of the Employee, state whether he/she is Employed, with details (If employed, a declaration of non-receipt of the claim in any form is to be attached) :

7. Place where the patient fell ill :

Hospital Treatment

8. Whether hospitalized or not :

9. If hospitalized whether in Govt: hospital or private (notified) hospital and name of hospital :

10 If hospitalized outside the State
   1. Whether the patient was on duty :
   2. Name of Institution :

11. If on special treatment outside the state
   1. Name of Institution :
   2. Whether Certificate of Director of Health Service as contemplated in Rule 7(a) is attached. :
   3. Whether prior sanction of Director Of Health Service has been obtained :

12. Last date of treatment :

Charges

13. Details of amount claimed (List of medicines Cash memo, and essentiality certificate Should be attached separately) :

(a) (i) Treatment in Govt: Hospital (Medicines) :Rs.

(ii) Treatment in private Institution (Bills to be certified indicating Emergency of the case) :Rs.

(b) 1. Charges for medicine :Rs.

2. Charges for treatment :Rs.

3. Charges for accommodation :Rs.

4. Charges for Lab.services etc. :Rs.

5. Charges for Diet :Rs.

14. Total amount claimed (in figures & words) :

15. List of enclosures

1.	Essentiality Certificate	: *Enclosed/Not enclosed
2.	List of Cash Bills	: *Enclosed/Not enclosed
3.	Certificate of Medical Officers	: *Enclosed/Not enclosed
4.	Certificate and declaration	: *Enclosed/Not enclosed

16. Declaration to be signed by the employee

I, hereby declare that the statements given above are true to the best of my knowledge and belief and the person for whom medical expenditure has been incurred is wholly dependant on me.

Signature of the employee

Place: Name:

Date: Designation:

Unit:

17. Declatation

a) I. . . . . (Name) employed in the . . . .(Name of Unit) hereby declare that I/my wife/son/daughter/mother/father have /has/had been under treatment at. . . . .(Name and place of hospital) during the period from. . . . . to. . . . . .and I/he/she have/has received the benefits of one system of treatment only and not taken advantage of ore than one system simultaneously.

(b) I, also declare that my wife/husband/son/daughter/dependant parent who is the patient is not employed anywhere and not in receipt of any remuneration.

Station:
Date:

Signature:

Name of employee:

Designation:

18. **<u>Certificate of the Unit Officer</u>**

1. Certified that the claim of Shri./Smt. . . . . …… .. . . … . . . . … . . . . was received in this office on. . . . . and the pay and scale of pay noted in his application are correct.

Station:
Date:

Signature of Unit Officer.

2. [To be certified by the Unit Officer when the claim is resubmitted after rectifying defects pointed out from C.O.]

Certified that he claim of Sri/Smt. . . . . was received in this Office on. . . . . .after rectifying the defects pointed out from Chief Office.

Station:
Date:

Signature of Unit Officer.

Tick mark the necessary entry