STATE BANK EMPLOYEES' CO-OPERATIVE CREDIT SOCIEITY LTD.[SBHECCS]
GUNFOUNDRY : HYDERABAD – 500 001

Estd: 1952 (Regd under Multi State Cooperative Societies Act 2002) Reg No. MSCS\CR\373\2010

Email Id: sbhempsociety@gmail.com **Site Address: sbhempccs.com**

APPLICATION FOR MEDICAL REIMBURSEMENT

Under Medical Assistance Reimbursement Fund Scheme – In terms of Bye-Law No.33 (D)

INDEX No. | | | | | |

Branch.: ..... Code No .....
Date : .....
A/c No : .....

The Secretary,
State Bank Employees' Co-operative Credit Society Ltd.,
Gunfoundry, Hyderabad – 500 001.

Dear Sir,

I, _____ member of State Bank Employees' Co-operative Credit Society Ltd., Regd.No. MSCS\CR\373\2010 apply for Medical Reimbursement on account of Medical expenses incurred by me in respect of Self / Dependent. I have read the Bye-laws of the Society together with the subsidiary working rules of the Medical Assistance Reimbursement Fund and agree to abide by the same along with amendments, if any, effected from time to time.

1. Name of the Applicant: Sri/Smt/Kum : _____
2. S/o W/o D/o : _____ Index No. _____ Mobile No. _____
3. Designation : _____ Branch / Department _____ HRMS No. _____
4. Name of the Patient : _____ Age : _____
5. Relationship with Applicant / Member : _____
6. Nature of Ailment : _____
7. Period of Treatment : From _____ to _____
8. Whether treated as : **Inpatient / Domiciliary** (Copy of Discharge Certificate from Hospital Required)
9. Total Expenditure incurred : Rs. _____ Sanction Note No. _____ Date: _____
10. Amount Sanctioned by Bank : Rs. _____
11. Amount Disallowed by Bank : Rs. _____
12. Amount Sanctioned by Staff Welfare, if any : Rs. _____
13. **Documents Enclosed** :
    a. Copy of Discharge Certificate of the hospital concerned.
    b. Copy of Sanction Note of the Bank.

Signature verified and Certified that the
particulars furnished above are true & Correct.

Yours faithfully,

Signature of Manager /
Head of Department
[with Seal]

Signature of the Member

Guidelines:

1. The Benefit of Scheme is extended to the existing members in respect of all ailments which need hospitalization and subsequent domiciliary treatment.
2. Application on the prescribed format along with enclosures should be submitted within 60 days from the date of the amount reimbursed by the Bank. Otherwise the claim will not be considered.
3. Applications / Claim rejected by the Bank for reimbursement of Special Medical Bill shall not be considered.
4. Financial assistance is extended to dependent spouse or children suffering with major ailments such as: Cancer/ Transplantation of Kidney/ Liver/ Brain/ Operation of Heart/ Lung/ Liver/ Brain/ Retina detachment/ Amputation/ bone marrow transplantation/ Total disability/ Loss of limbs due to Paralysis/ Accident.