



**Gowd Saraswat Brahman Sabha, Mumbai.**  
101, Sreenidhi, 76, Bhau Daji Road, Opp. Bank of Baroda,  
Matunga (C. R.), Mumbai - 400 019

## **APPLICATION FORM**

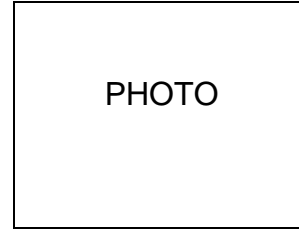
**“GSB SABHA SENIOR CITIZENS’ MEDICAL WELFARE FUND –  
PRINCIPAL SPONSOR & DONOR, SHRI GURPUR DATTANAND BHAT  
IN MEMORY OF HIS LATE WIFE, SMT. SHANTA D. BHAT”.**

### **REIMBURSEMENT OF DOMICILIARY MEDICAL EXPENSES**

Application No. : \_\_\_\_\_

Date & Day : \_\_\_\_\_

To,  
The Managing Committee,  
Gowd Saraswat Brahman Sabha, Mumbai,  
101, Sreenidhi, 76, Bhau Daji Road,  
Opp. Bank of Baroda, Matunga (C.R.),  
Mumbai 400 019



Dear Sir/Madam,

I hereby apply for assistance under the captioned Welfare fund of the Sabha and for this purpose, I furnish the following particulars:-

**1) Name of the applicant :**

First Name	Middle Name	Surname	Sex
			F / M

**2) Date of Birth** : \_\_\_\_\_ **Age (completed years)** : \_\_\_\_\_

**3) Gotra** : \_\_\_\_\_ **Kuladevata** : \_\_\_\_\_

**4) Residential Address:** \_\_\_\_\_

Contact No: Landline: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email id \_\_\_\_\_

5) **Alternative Contact No:** Landline: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Name & address of that person: \_\_\_\_\_

6) a) **Total number of people in the house:**

b) **Total Annual Income of the family:** (please fill all details in the following table)

Name	Relationship with the applicant	If staying with the applicant	Gross Annual income (Rs.)
	Self		
Total annual income of the family (Rs.)			

7) **Nature of illness/Ailment:** \_\_\_\_\_ **Total Expenditure:** - \_\_\_\_\_

8) **Name of the Doctor:** \_\_\_\_\_ **Registration no.:** \_\_\_\_\_

**Address of the Doctor :** \_\_\_\_\_

\_\_\_\_\_ **PIN**

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9) **Are you covered under any Mediclaim Policy:** Yes / No (please tick ✓ whichever is applicable)

If yes, policy details:

Insurance company	Policy no. and date

Amount claimed and settled by Insurance Company:

Claimed: ` \_\_\_\_\_ Settled: ` \_\_\_\_\_

10) **Benefit(s) availed from any other source(s):** - Yes/ No (please tick ✓ whichever is applicable)

If Yes, please mention the details of the same :

Name of the Institution: \_\_\_\_\_ Amount ` \_\_\_\_\_

11) **Whether benefit is also required under Destitute Fund of Sabha under which quarterly allowance is disbursed** - Yes/ No (please tick ✓ whichever is applicable)

## DECLARATION

"I hereby state that I have read the Rules of this welfare Fund and agree to abide to the same. The above information is true to the best of my knowledge and if the same is found to be false, I will, on demand by the Sabha, return the relief granted to me.

Kindly grant me assistance under Sabha's Welfare fund captioned above and credit the same to my SB account no : \_\_\_\_\_ with \_\_\_\_\_  
Bank \_\_\_\_\_ Branch." (Copy of cancelled cheque attached)

Yours faithfully

Signature of the applicant

**Recommended by :**

First Name	Middle Name	Surname	Sex	Age
			F / M	

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### **REMARKS/OBSERVATIONS/CERTIFICATION OF THE DOCTOR(s) APPOINTED BY THE SABHA**

Ongoing through the documents provided and on review of the same, I/We hereby certify that the illness/ailment indicated and the line of treatment provided is correct. The claims can be further processed based on other eligibility criteria under this welfare scheme.

Observations, if any:

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**Name of the Doctor :** \_\_\_\_\_ **Registration no.:** \_\_\_\_\_

**Address of the Doctor :** \_\_\_\_\_

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Signature of Doctor: \_\_\_\_\_ Date \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Received Date: \_\_\_\_\_

**Scrutinized by:**

1. a. Name : \_\_\_\_\_

b. Designation in the Sabha : \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

2. a. Name : \_\_\_\_\_

c. Designation in the Sabha : \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

**Observations on Scrutiny :**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Considered by Managing Committee On : \_\_\_\_\_

Managing Committee Decision :

\_\_\_\_\_  
\_\_\_\_\_