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

PHOTO

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 | | | | | | |

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	

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:

_____

_____

Name of the Doctor : _____ Registration no.: _____

Address of the Doctor : _____

_____

Signature of Doctor: _____ Date _____

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 :

_____

_____