STATE BANK OF INDIA EMPLOYEES' (M.S. PATEL)
CO-OPERATIVE CREDIT SOCIETY LTD., MUMBAI
State Bank of India, Mumbai Main Branch Building, Mumbai Samachar Marg,
Fort, Mumbai - 400 023. Tel.: 022-2266 4360 / 2266 1780

Inward No. _____

Date : _____

Membership No. | | | | | |

Date of joining the Bank | D | D | M | M | Y | Y | Y | Y |

Date of confirmation | D | D | M | M | Y | Y | Y | Y |

Date of joining the scheme | D | D | M | M | Y | Y | Y | Y |

P. F. Index No. : | | | | | | | |

Mobile No.: | | | | | | | | | | |

APPLICATION FORM FOR REIMBURSEMENT UNDER "MEDICAL AID & REIMBURSEMENT OF MEDICAL EXPENSES TO MEMBERS SCHEME" [MARMEM]

[Please use separate form for a) Hospitalisation b) Loss of pay on medical ground]

1. a) Name in full : _____

   b) Designation : _____

2. Whether reimbursement is claimed for self /or member of the family.
   Please provide following details if, claimed for member of family.

   Name : _____ age _____

   Relationship : _____

*3. Reasons and nature of operation : _____

*4. Date of operation : _____

*5. Duration of treatment / Hospitalisation (with Dates) : _____

6. Nature of sickness of disease : _____

7. Total
   Actual expenditure incurred (Proof to be enclosed) : Rs. _____

8. Less
   Medical expenses reimbursed from the quota available / under the Improved Medical Aid Scheme **(A Proof of which is enclosed herewith)** ★ : Rs. _____

9. Net
   Amount applied for **(If claim is over Rs. 5000/- Please enclose working sheet)** ★ : Rs. _____

10. In case of claim ON LOSS OF PAY on medical ground
    a) Total amount of salary / allownces in detail (not paid for the period from _____ to _____)
    (Proof to be enclosed for Leave on loss of pay and Salary particulars)

    b) Amount of medical expenses reimbursment received from [relates to item No. (8 + 9)]
    Bank _____ Rs. _____
    Society _____ Rs. _____

★ **DOCUMENTS REQUIRED CHECKLIST :**

1. HRMS Application Particulars (Medical Reimbursement)
2. HRMS Saction Particulars (Medical Reimbursement) and Working Sheet
3. Sactioned Letter
4. Discharge Copy

Application to be forwarded through the Branch / Department along with a typed list of the medical bills and also verified by the Executive Member.

Particulars of Family Members depedent on me :

Nos.	Name/s	Age	Relationship	Occupation	Income
(1)					
(2)					
(3)					
(4)					

STATEMENT OF ACCOUNTS

Sr. No. (1)	Date of expenditure (2)	For Self / family (3)	Particulars of Bills / Cash memo no etc. (4)	Amount Rs. (5)
1.				
2.				
3.				
4.				
5.				

I, Shri/Smt./Kum./ _____ hereby solemnly declare that the particulars furnished above by me are true and that the treatment for which reimbursement has been requested, has been actually availed of by none other than myself and/or my family member/s for the reasons and the period stated in the Medical Certificate attached to my application dated_____ duly supported by bills, vouchers etc. for reimbursement of the Medical Expenses amounting to Rs._____ actually incurred by me. I also certify that no other amount of income has been omitted to be detailed above.

_____
Signature of the Member

Place : _____

Date : _____

Name : _____

Designation : _____

Branch / Deptt. _____

CERTIFICATE

Shri _____ Executive Member for _____ District

declare that the expenses incurred by Shri _____

Membership No. _____ working at_____

has been actually incurred and verified by me.

_____
Signature of Executive Member