Annexure - IV

Application for Hospitalisation under Post-Treatment Payment Facility in respect of self or member(s) of family

Staff : Supervising / Award (for 23 specified serious disease)

State Bank of India,
…………………………………………… Branch / Office (Code No.)
……………………………………………………Administrative Office
……………………………………………………………………………Circle

Date :

01. Name of Employee in full (In block letters) :
PF Ind. No. & Date of Birth : ……………………………………… & DD / MM / YYYY

03. Designation / Grade :

04. Department / Section :

05. Name of the patient :

06. Relationship of the patient with the employee :

07. Name of the disease (supported by attending Doctors / Hospital /Nursing Home Certificate) :

08. Name of the Hospital & date of admission :
: Admitted on …………………/ To be admitted on................

09. (a) Medical Expenses to be debited to : ……………………………………………………………Branch / Office
……………………………………………………………… Code No.

Please arrange for admission under Post-treatment Payment Facility as stated above in terms of Head Office Circular letter No………………………………………………………………………………, dated…………………………….

Dated:

(Signature of the employee)
Contact No.____________________

Declaration:

I Shri / Smt. …………………………………………………………… hereby solemnly declare that :

i) I am not entitled to any reimbursement of contribution towards medical expenses under personal accident policy or under any claim in respect of accident from any other source.

ii) My family member(s) viz. parents, wife, son or daughter are fully dependent on me.

iii) The income of my dependent family member for whom hospitalization is required does not exceed Rs. 10,000/- p.m. (Rupees ten thousand only) from all sources.

(Signature of the employee)

Contd. to …….2

Signature verified

I, the undersigned hereby certify that all the particulars furnished herein by Shri / Smt. …………………………………………………………………………… are true to the best of our knowledge and belief.

Asst. General Manager / Chief Manager / Branch Manager
………………………..…………………………………………..Branch / Office

Recommendation and stipulations:

We have examined the proposal and recommend for Post-Treatment Payment Facility in favour of Shri / Smt. ……………………………………………………………………………………………(Name of employee) for his / her dependent family member at …………………………………………………………………………… hospital (Name of Hospital). Please issue Post-treatment Payment Facility credit letter to the Hospital Authority with following stipulations:

i) No cash disbursement / reimbursement will be made by the Bank.
ii) Payment of all medical expenses will be made directly to the Hospital Authority.
iii) Branch / Office to be debited : ……………………………………………………………………
iv) Branch / Office Code No. : ……………………………………………………………………

Branch Manager/ Chief Manager/ Asst. General Manager
(Branch / Office)

Regional Manager

Dy. General Manager (B & O Offices / Direct Control Branches / Mid-Corporate / Corporate Centre Establishments) /
CDO (for other Circle)

Important guidelines for the staff members

For the patient admitted on emergency basis	For the patient who planned for admission for treatment
Collect diagnosis advice from Hospital	Take printout of this prescribed application form from HR site > Circle Welfare > medical facilities
Submit this form duly filled up and signed along with hospital advice at the branch / Office, where posted	Submit the form enclosing Doctor's prescription duly vetted by Bank's medical Officer / Auth. Bank's MO at the branch / Office, where posted.
Send the application form to Z.O., HR Deptt. (for treatment in Kolkata Circle) / LHO, HR Deptt. (for Out-side Circle) duly **recommended** by the Head of the Branch / Office and the Controller (**RM / AGM**)	Send the application form to Z.O., HR Deptt. (for treatment in Kolkata Circle) / LHO, HR Deptt. (for Outside Circle) duly **recommended** by the Head of the Branch / Office and the Controller (**RM / AGM**)

For the staff of other Circles : Recommendation should reach to us from the Circle Development Officer of the respective Local Head Office, where the staff member is posted.

State Bank of India,
Local Head Office,
H R Deptt.,
Samriddhi Bhavan, 6th Floor,
1 Strand Road,
Kolkata – 700 001
Tel No. : 033-22437754,
Fax No. : 033-22437754
033-22437753

Award Staffs are eligible for following 23 specified serious diseases

(1) Tuberculosis, **(2)** Cancer, **(3)** Leprosy, **(4)** Mental disease, **(5)** Accidents of serious nature, **(6)** Cardiac ailment, **(7)** Kidney ailments, **(8)** Paralysis, **(9)** Tumour, **(10)** Small Pox, **(11)** Pleurisy, **(12)** Diptheria, **(13)** Cerebral Malaria, **(14)** Dog bite/Snake bite, **(15)** Epilepsy if there is 'Status Epilepticus', **(16)** Non-alcoholic Cirrhosis of Liver, **(17)** Haemophelia, **(18)** Purpura,**(19)** Thalassaemea, **(20)** Typhoid with complication like **(a)** Intestinal Perforation or intestinal obstruction **(b)** Typhoid Psychosis or Brain damage, **(21)** Parkinson's disease, **(22)** Cerebral Palsy, **(23)** AIDS

LETTER OF CREDIT **Annexure-I**

To

Date:

Dear Sir/ Madam,

ADMISSION UNDER POST-TREATMENT PAYMENT FACILITY

We furnish below the details of the employee/ the patient for cashless treatment at the hospital:

I.	Name of the Employee	:
II.	P.F No. of the Employee	:
III.	Designation and Grade of the employee	:
IV.	Present Place of Posting	:
V.	Name of the Patient	:
VI.	Relationship with the employee	:
VII.	Entitled class/ grade of Admission	:
VIII.	Bed Entitlement of the Employee per Day	:
IX.	Date of Admission	:
X.	Admission under Dr.	:
XI.	Nature of Ailment	:
XII.	Estimated expenses for the Treatment	:
XIII.	Period of treatment at the Hospital	:

(Actual number of days as estimated by the attending doctor at the hospital, subject to a max. period of 30 days. In case stay at the hospital for the treatment is prolonged beyond 30 days, a fresh Credit Letter is to be obtained form the Bank before the expiry of 30 Days, based on the recommendations of the attending doctor for the said extension by specifying further period of stay.)

1. We shall be glad if you please arrange for his/her admission and extend him/ her every possible medical care.
2. The bill in this connection may please be forwarded to us for necessary payment. In this connection please note that:
   a) Under the post-treatment payment facility arrangement, every patient will be admitted only in the entitled class as indicated in para 1 above. No deviation will be allowed in this regard. In case, admission in higher class is required, the entire additional expenses will have to be recovered from the concerned employee by the Hospital authorities before discharge of the patient from the Hospital.
   b) In case of treatment of dependents, the payment of medical expenses to the Hospitals will be restricted to 75% of the prescribed entitlement whichever is lower. The residual 25% will have to be paid by the employee concerned before discharge of the patient from the Hospital.
   c) Our concerned employee is requested to carry his / her Identity Card as a proof of identification and produce the same before the hospital authority as and when necessary.

Yours faithfully,

(Senior Bank Medical Officer, LHO Concerned/

Bank Medical Officer, ZO/AO Concerned/

Administrative Officer, Medical Department,

Corporate Centre, Mumbai)