CSBF/2021-2022

CENTRAL STAFF BENEFIT FUND

APPLICATION FOR FINANCIAL ASSISTANCE FOR SICKNESS

STAFF IN GRADE PAY UPTO Rs.4600/- (LEVEL-7) ONLY ARE ELIGIBLE TO APPLY

1.	Name of the applicant (S/Shri/Smt/MS)	:							
2.	P.F No./ Staff No.	:							
3.	Bill Unit No.	:							
4.	Design /Office	:							
5.	Pay in Pay Matrix	:	Level.		Pay Rs.		Grade pay (Rs.)		
6.	Telephone No.	:	Railway			Mobile			
7.	Whether the employee belongs to SC/ST/OBC/UR/PH ✓ (Tick relevant column)	:	SC	ST	OBC	UR	PH		
8.	Claimed for ✓ (Tick relevant column)	:	Self		Family Member		Dependent		
9.	Relationship to the employee								
10.	Nature of Treatment	:							
11. A	Place and Period of Treatment	:							
B	Whether any claim has been made to PCMD/MD/CMS/RH of the concerned HQ/Division/Unit (Yes/No) ✓ ((Tick relevant column)	:	Yes			No			
C	If claimed, the quantum of amount sanctioned	:	Rs.						
12.	Details of earlier claim from CSBF	:	Year			Amount Rs.			
13.	Incidental expenditure in case of Cancer, TB, AIDS etc.	:							
14.	Whether original bills available? ✓ (Tick relevant column)	:	Yes			No			
15.	Supporting Documents to be enclosed ✓ (Tick relevant column)	:	Enclosed			Not Enclosed			
A	Hospital Documents with **original Discharge Summary**	:							
B	Original bills (Nos.)	:							
C	Original Bills listed date- wise with total claim and number of bils	:							
D	Total Amount Claimed	:							

(Signature of Employee)
Designation/Station

CERTIFICATE BY DEPARTMENT

The particulars furnished in S. No. 1 to 15 'D' have been checked and found correct. Original bills have been verified and forwarded to the Chairman / CSBF Committee, Headquarters office, Chennai - 600003 for consideration.

Office Stamp:
Date :

Signature & Designation of the
controlling Officer

DECLARATION BY THE EMPLOYEE

I, (Name of the Employee .....
(Designation).....,do hereby declare that I have claimed monetary assistance for medical expenses from CSBF for Self/Wife/Son/Daughter /Dependents who are fully dependent on me. I further declare that I have not claimed so far and will not claim here after any monetary reimbursement from any medical insurance company or from the CMD or from any other source in respect of the treatment for which assistance is being granted from CSBF.

Date:
Place: (Signature of Employee)

I have personally verified the identity of the family members/dependents of the claimant.

Counter signed by the Personnel Officer

Date :
Place:

Name:
Designation:

Seal:

Note : Only applications from which is above Rs.50,000/-(Rupees Fifty Thousand) should be recommended for financial assistance from CSBF through proper channel by the Offices/Units with proper justification and necessary endorsement of the concerned Officers of Personnel Department.

(Please ensure that all the particulars called for is filled without any overwriting)