CENTRAL STAFF BENEFIT FUND APPLICATION FOR FINANCIAL ASSISTANCE FOR SICKNESS STAFF IN GRADE PAY UPTO Rs.4600/- (LEVEL-7) ONLY ARE ELIGIBLE TO APPLY

(S/Shri/Smt/MS)		(III)					
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Bill Unit No.	1:		elinguate electricities en processo de la company			- Charles and Assessment and Assessm	
Design /Office	1:	New Control of the Co			7)		
Pay in Pay Matrix	:	Level. Pay Rs.		s.	Grade pay (Rs.)		
Telephone No.	1:	Railway			Mobile		
		- Company of the Comp		11.3			
Whether the employee belongs to SC/ST/OBC/UR/PH ✓ (Tick relevant column)	:	SC	ST		ОВС	UR	PH
Claimed for ✓ (Tick relevant column)		Self Family Member		Dependent			
Relationship to the employee	1			1-1-1-1			
Nature of Treatment	1:						
Place and Period of Treatment				, and a state of the state of t			
Whether any claim has been made to PCMD/MD/CMS/RH of the concerned HQ/Division/Unit (Yes/No)		Yes No					
If claimed, the quantum of amount sanctioned	:	Rs.					
Details of earlier claim from CSBF	1:	Year			Amo	Amount Rs.	
Incidental expenditure in case of Cancer, TB, AIDS etc.	1:						
Whether original bills available? ✓ (Tick relevant column)	:	Yes No					
Supporting Documents to be enclosed ✓ (Tick relevant column)		Enclosed Not Enclosed					
Hospital Documents with original Discharge Summary	:						
Original bills (Nos.)	:	Hara 1960 Darregiti O are est ta a activities					
Original Bills listed date- wise with total claim and number of bils	:	THE STATE OF THE PROPERTY OF T					
Total Amount Claimed	1:		***********		and the second s		and the second s
	(S/Shri/Smt/MS) P.F No./ Staff No. Bill Unit No. Design /Office Pay in Pay Matrix Telephone No. Whether the employee belongs to SC/ST/OBC/UR/PH ✓ (Tick relevant column) Claimed for ✓ (Tick relevant column) Relationship to the employee Nature of Treatment Place and Period of Treatment Whether any claim has been made to PCMD/MD/CMS/RH of the concerned HQ/Division/Unit (Yes/No) ✓ ((Tick relevant column) If claimed, the quantum of amount sanctioned Details of earlier claim from CSBF Incidental expenditure in case of Cancer, TB, AIDS etc. Whether original bills available? ✓ (Tick relevant column) Supporting Documents to be enclosed ✓ (Tick relevant column) Hospital Documents with original Discharge Summary Original Bills listed date- wise with total claim and number of bils	(S/Shri/Smt/MS) P.F No./ Staff No. Bill Unit No. Design /Office Pay in Pay Matrix Telephone No. Whether the employee belongs to SC/ST/OBC/UR/PH ✓ (Tick relevant column) Claimed for ✓ (Tick relevant column) Relationship to the employee Nature of Treatment Place and Period of Treatment Whether any claim has been made to PCMD/MD/CMS/RH of the concerned HQ/Division/Unit (Yes/No) ✓ ((Tick relevant column) If claimed, the quantum of amount sanctioned Details of earlier claim from CSBF Incidental expenditure in case of Cancer, TB, AIDS etc. Whether original bills available? ✓ (Tick relevant column) Supporting Documents to be enclosed ✓ (Tick relevant column) Hospital Documents with original Discharge Summary Original bills (Nos.) 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No./ Staff No. Bill Unit No. Design /Office Pay in Pay Matrix Telephone No. Whether the employee belongs to SC/ST/OBC/UR/PH / (Tick relevant column) Claimed for / (Tick relevant column) Relationship to the employee Nature of Treatment Whether any claim has been made to PCMD/MD/CMS/RH of the concerned HQ/Division/Unit (Yes/No) / ((Tick relevant column) It claimed, the quantum of amount sanctioned Details of earlier claim from CSBF Incidental expenditure in case of Cancer, TB, AIDS etc. Whether original bills available? / (Tick relevant column) Hospital Documents with original Discharge Summary Original Bills (Nos.) Original Bills listed date-wise with total claim and number of bils



(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 Em	nployee
(Designation)	,do hereby declare that I
have claimed monetary as	ssistance for medical expenses from CSBF for
Self/Wife/Son/Daughter /Deper	ndents who are fully dependent on me. I further declare
that I have not claimed so far a	nd will not claim here after any monetary reimbursement
from any medical insurance of	ompany or from the CMD or from any other source in
respect of the treatment for whi	ch assistance is being granted from CSBF.
Date:	part workship of parts and parts and parts
Place:	(Signature of Employee)
and the second s	e identity of the family members/dependents of the
claimant.	
	Countar signed by the Personnel Officer
	Counter signed by the Personnel Officer
Date :	Name:
Place:	Designation:
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	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)

