APPLICATION FOR HOSPITALISATION UNDER POST-TREATMENT PAYMENT FACILITY
IN RESPECT OF SELF OR MEMBER(S) OF FAMILY
STAFF : SUPERVISING / AWARD (FOR 23 SPECIFIED DISEASE)

State Bank of India,
_____**Branch / Office (Code No.)**
_____**Administrative Office**
_____Circle

1. Name of Employee in full (in block letters) :_____
2. PF Index No. :_____
3. Age / Date of Birth :_____ DD / MM / YYYY
4. Contact No.(s) / Email Id :_____
5. Designation / Grade :_____
6. Department / Section :_____
7. Name of the Patient :_____
8. Relationship of patient with the employee : Self / Wife / Son / Daughter / Father / Mother **(CONFIRMATION CUM UNDERTAKING BY CONTROLLER IS ENCLOSED)**
9. Name of the disease (supported by attending Doctors/ Hospital / Nursing Home Certificate) :_____
10. Name of the Doctor who referred :_____
11. Name of the Hospital :_____
12. Date of admission : admitted / to be admitted on DD/ MM/YYYY
13. No. of days of Stay at Hospital :_____
14. Approximate Cost of Treatment (estimate encl):_____
15. 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: DD/ MM/YYYY

Dated: DD/ MM/YYYY

(Signature of the employee)

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.

Assistant General Manager / Chief Manager / Branch Manager
_____Branch / Office

Dated: DD/ MM/YYYY

Recommendation and stipulations:

We have examined the proposal and recommend for Post- Treatment Payment Facility is favour of Shri / Smt. _____(Name of employee) for his / her dependent family member at_____hospital (Name of Hospital). **Further, we also confirm that , Shri/Smt_____is fully dependent of Shri/Smt.....**

(name of the employee) and genuineness has also been verified by us in this regard (confirmation is enclosed)

We, therefore, request to 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 / Regional Manager (Branch / Office)

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

Annexure A

CONFIRMATION CUM UNDERTAKING*

(Applicable in case of medical expenses of Rs.50000/ and above for dependent family member)

I,..... (Name) S/O Shri....., presently working as.....

.....(designation) at .....(Name of Department/Branch/Office), confirm that

Shri/Smt.....(name of the employee) is working under me and he/she has applied for medical

advance/ post treatment payment facility/ medical bill for Rs..... .....(amount in words)

for his/her dependent family member Shri/Smt.....(Name of dependent)

In this connection, the genuineness has been verified by me and I confirm that Shri/Smt .....

is actually dependent on Shri/Smt/Ms..... .....(name of the employee) as per Bank's

extant instructions.

Signature

Date:

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 print out 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 LHO, HR Deptt. (4th floor) duly recommended by the Head of the Branch / Office and the Controller (RM / AGM)	Send the application form to LHO, HR Deptt. (4th floor) duly recommended by the Head of the Branch / Office and the Controller (RM / AGM)

For other Circles : Recommendation should reach to us from the **Dy. General Manager & Circle Development Officer** of the respective **Local Head Office**, where the staff member is posted.State Bank of India, H R Deptt., 4th Floor, 'A ' Wing, Local Head Office, Administrative Building, Moti Mahal Marg, Lucknow (U P) – 226001Tel No : 0522-2295299 / Email : agmphr.lholuc@sbi.co.in / welfare.lholuc@sbi.co.in **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 / Snake bite, **(15)** Epilepsy if there is 'Status Epileptics', **(16)** Non - alcoholic Cirrhosis of Liver, **(17)** Haemophilia, **(18)** Purpura, **(19)** Thalassemia, **(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