

FORM A-IV**APPLICATION FOR FINANCIAL ASSISTANCE FOR MEDICAL TREATMENT**

Running Serial of Application with Date (to be filled by Accountant, SATSA, WB)		Stamp Size Photo of Member	Stamp size Photo of Patient
Serial No.	Date of Receipt		
1.	Name of Member		
2.	Member ID		
3.	WB Health Scheme Enrollment No.		
4.	Name of Patient		
5.	Relation with member (Tick Suitable)	Self / Spouse/ Ward	
6.	Age of patient (If minor)		
7.	Ailment for which treatment is required		
8.	Nature of treatment (Tick Suitable)	Only Medication / Operation / Chemotherapy	
9.	Name of Specialist Doctor		
10.	Name of Hospital/ Nursing Home		
11.	Expected Date of Admission		
12.	Estimated/ Expected Expenditure from Admission to Discharge (Rs) [Attach document]		
13.	Name of Bank with Branch maintaining salary account of member (Attach self attested photocopy of Cheque)		
14.	Whether Spouse is a Group A Employee under State / Central Govt. or Teaching Professional in Govt. Aided Body/ Institution (Name of Department & Office, Institution with address)		

Declaration:

- I have not availed / availed (tick applicable) similar assistance from SATSA, West Bengal previously.
- I have received Rs _____ (Rupees _____) on _____ and have repayed Rs _____ till last month.
- The above information is true to the best of my knowledge.
- I shall repay the amount in _____ installments starting from **1st day of** _____ (Month), _____ (Year).

Signature of Member/ Spouse (if member is patient)
(Contact no. of Signatory _____)

Recommended and forwarded to the Accountant; SATSA, WB

District Secretary,

District Unit