Annexure XIV

**FORM A-IV**

**APPLICATION FOR FINANCIAL ASSISTANCE FOR MEDICAL TREATMENT**

Stamp size Photo of Patient

Stamp Size Photo of Member

Running Serial of Application with Date (to be filled by Accountant, SATSA, WB)

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 fromAdmission 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:**

1. I have not availed / availed (tick applicable) similar assistance from SATSA, West Bengal

 previously.

2. I have received Rs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Rupees )

 on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have repayed Rs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ till last month.

3. The above information is true to the best of my knowledge.

4. 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**