## SOUTHERN RAILWAY Application for Financial Assistance for Relief of Distress/ Sickness

1.	Name of the applicant (Shri/Smt/Ms.)	;						
2.	IPAS Number (PF No.)	:						
3.	HRMS ID							
4.	Bill Unit No.	:						
5.	Design /Office/Department	:						
6.	Pay Level in Pay Matrix & Pay	:						
7.	Bill Preparing Office							
8.	Telephone No.	:	Ra	ilway	Мо	bile		
9.	Community	:	sc	ST	OBC	UR		
10.	Claimed for	:	Self	Family M	lember	Dependent		
11.	Relationship to the employee							
12.	Nature of Treatment in brief	;						
	(maximum 500 characters)							
13	Place of Treatment	:	Place:					
	Period of Treatment- (Dates)		From:	To				
14	Whether any claim has been made to	;	Yes/No	If 'Yes' date	of submiss	ion of		
	PCMD/MD/CMS/RH of the concerned			Application				
	HQ/Division/Unit (Yes/No)	-1 E-	a an implemen		ا ماداندالد اد	ias alaim		
4.5	Please Note: The claimant who applie			sement are n	_			
15	Details of earlier claim from CSBF(if any)	:	Year		Amount Re	5.		
16	Incidental expenditure if any, in case of							
.0	Chronic disease, such as Cancer, TB,	•						
	AIDS etc.							
17	Total Amount Claimed	•						
		·						
					gnature of I			
	DECLARATION	<u>NC</u>	BY THE EN		esignation/S	Station		
	I, (Name of the Employee							
(De	esignation)					at I have		
•	med monetary assistance for medical e			•				
	pendents who are fully dependent on me.	-				•		
will	not claim here after any monetary reimbu	ırse	ment from	any medical	insurance o	ompany or		
fro	n the PCMD or from any other source in re	spe	ct of the tre	atment for wh	ich assistan	ice is being		
gra	nted from CSBF.							
_								
Dat	•			<b></b> -				
Place:			(Signature of Employee)					

## FORWARDED BY DEPARTMENT

This is to certify that all the particulars furnished in S. No. 1 to 17 have been checked and found correct.

Off	īce Stamp:					
Date:		Signature & Designation of the Controlling Officer with seal				
	••••••					
	CERTIFICATE BY PERSONNEL DEPARTMENT					
		e identity the family members/dependents of the claimant and Summary, Original Bills and copy of Reports have been				
	The employee belongs to Bill Unit No:					
		Counter signed by the Personnel Officer				
	Date :	Name:				
	Place:	Designation:				
		Seal:				
Th	ne following Documents are to be	e enclosed along with the application:				
i.	_	ii. Original Bills				
iii.	Medical Report	iv. List of Bills Details Date wise				
V.	Copy of UMID of the beneficiary	•				

Note: Only applications for 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. Applications for financial assistance below Rs.50,000/- should be dealt by DSBF Committee.

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