ANNEXURE VIII

KERALA STATE CO-OPERATIVE EMPLOYEES WELFARE BOARD

APPLICATION FOR GRANT OF MEDICAL TREATMENT

1) a) Name and Address of the applicant (Employee) (in block letters) :

   b) Code Number of the Employee :

   c) Phone/ Mobile No. of the Employee :

2) a) Name and Address of the Institution in which the employee is working. :

   b) Phone / Mobile No. of the institution :

3) a) Date of Birth and Age of the Employee :
   b) Date of entry in service :
   c) Date of Retirement :

4) Date of option to come over to the Welfare Board Scheme. :

5) Whether the recovery was regularly effected and remitted to the Welfare Board :

6) Name of Disease diagnosed :

7) Any financial assistance received from Govt./ Govt. Agencies/ Govt. Insurance coverage for the treatment?
   If Yes, give details :

8) Whether an original medical certificate is attached in the prescribed Annexure-X format issued by Competent medical doctor in the case of other than Permanent medical disability conditions. :

9) Any Financial Assistance for Medical Treatment availed from the Board previously?
   (Give details with the Amount sanctioned) :

10) The amount claimed. :

I, ... certify that the particulars given above are correct and also promise that in any reason the operation need not be undertaken, the whole amount received by me will be refunded to the Welfare Board within a month.

Place:

Date: Signature of the employee

I certify that the particulars given above are correct and recommend to pay the amount.

Place :
Date :

(Name & Signature)
President of the Institution

(Name & Signature)
Chief Executive of the Institution

(Office Seal)

Countersigned
Head of Department/District/ Taluk level officer of the concerned administrative department of government.

Place:
Date:

(Office Seal)

Signature
(Name and Designation)