CHECK LIST AND VARIOUS FORMS ON POLICE WELFARE MEASURES

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West Bengal Police Medical Insurance Policy
Enrollment Form

FORM – A

Data of members in excel file format for enrolment under West Bengal Police Medical Insurance Policy issued by National Insurance Co. & TPA Genins India TPA Lt. for the year.....
Maximum **4 persons** are allowed on 1 (Self) +1 (Spouse) + 2 (Son(s) / Daughter (s) / Brother(s)/Sister(s)

*1. **I want to take policy by paying premium of Rs...../-***

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Wife/Husband			F/M		
3	GINI060				Son/Daughter			M/F		
4	GINI060				Daughter/Son			F/M		
5	GINI060				Brother/ Sister			M/F		
6	GINI060				Sister/ Brother			F/M		

Signature of the Primary member

Address :

FORM – B

Data of members in excel file format for enrolment under West Bengal Police Medical Insurance Policy issued by National Insurance Co. & TPA Genins India TPA Lt. for the year.....

Maximum 6 persons are allowed on 1 (Self) +1 (Spouse) + 2 (Son(s) / Daughter (s) / Brother(s)/Sister(s)+2 Either Parents or In-laws

*1. **I want to take policy by paying premium of Rs...../-***

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID **(name of year)**	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Wife/Husband			F/M		
3	GINI060				Son/Daughter			M/F		
4	GINI060				Daughter/Son			F/M		
5	GINI060				Brother/ Sister			M/F		
6	GINI060				Sister/ Brother			F/M		
7	GINI060				Father			M		
8	GINI060				Mother			F		
9	GINI060				Father-in-law			M		
10	GINI060				Mother-in-law			F		

Signature of the Primary member

Address :

FORM - C

For Retired Police Personnel

I want to become Member of West Bengal Police Medical Insurance Policy by paying premium of Rs...../-. **for the year.....**

Sl No	Last Year Genins Card ID No. **(name of year)**	PPO NO.	Pension Sanctioning Authority	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**					**SELF**			**M/F**		
2	**GINI060**					Wife/Husband			F/M		
3	GINI060					Handicapped Son/Daughter			M/F		
4	GINI060					Handicapped Daughter/Son			F/M		

Signatures of the Primary member

Address :

FORM – D

For Family Pension Holders (Aged upto 60 years)

I want to become Member of West Bengal Police Mediclaim Policy by paying premium of Rs...../-. **for the year.....**

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Son/Daughter			M/F		
3	GINI060				Daughter/Son			F/M		

Signature of the Primary member

Address :

FORM – E

For Family Pension Holders (Aged 60 years above)

I want to become Member of West Bengal Police Mediclaim Policy by paying premium of Rs...../-. **for the year.....**

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relatio n-ship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	GINI060				SELF			M/F		

Signature of the Primary member

Address :

Check list for Reimbursement under Mediclaim Policy for Police Employees

All reimbursement claims to be submitted to the office of TPA through their sector representative(s) with the following documents:

- ✓ Filled up Claim Form mentioning claim amount, ID Card No., GPF No., Phone No., Bank Account No., Name of Branch of Bank and IFS Code No.
- ✓ IRDA guided claim Form "Part-B"
- ✓ Advice for admission/ Emergency Admission Note.
- ✓ Discharge Certificate.
- ✓ Discharge Certificate/ Day Care Certificate and all Bills Vouchers in case of Day Care Treatment.
- ✓ Final Bills with break up and Numbered money receipt & cash memo for Doctor's Fees.
- ✓ Prescription / Medicine Bills / Pathological test reports.
- ✓ Implant Sticker / Tax in voice.
- ✓ Prescription / Medicine Bills / Pathological test reports etc. for treatment of 30 days pre hospitalisation and 60 days post hospitalisation.
- ✓ MLC copy/ FIR copy/ Self declaration in case of accident.
- ✓ Prescription/ Discharge Certificate/ Final Bill/ Recommendation of Unit Head through Police Directorate for Buffer Claim.
- ✓ All papers to be submitted in original.

Personal Accident Policy for Police Employees and Retired Personnel

Enrollment Form

Declaration for PA Claim

Assignment (applicable when proposal is for own life)

I have taken PA Policy issued by National Insurance Company Limited by paying premium of Rs...../-

I..... (Name and Brass no of the Police Personnel / Ministerial Staff / Employee) do hereby assign the moneys payable in the event of my death by National Insurance Company Limited to ..... (Name of the person to receive compensation) who is my ..... (relation with the member) and I further declare that his/her receipt shall be sufficient to discharge the Company.

Place..... Date ..... Signature of the Proposer

Assignment witnessed by

Sl. No.	Name	Address	Signature

Name, Rank and Signature along-with official seal of the person verifying this proposal

(Officer of D. S. P. and above rank must sign this form)

Declaration for PA Claim

Assignment (applicable when proposal is for own life)

I have taken PA Policy issued by National Insurance Company Limited by paying premium of Rs...../-

I..... (Name and PPO No of the Retired Police Officer) do hereby assign the moneys payable in the event of my death by National Insurance Company Limited to ..... (Name of the person to receive compensation) who is my ..... (relation with the member) and I further declare that his/her receipt shall be sufficient to discharge the Company.

Place..... Date ..... Signature of the Proposer

Assignment witnessed by

Sl. No.	Name	Address	Signature

Name, Rank and Signature along-with official seal of the person verifying this proposal

(Officer of D. S. P. and above rank must sign this form)

Check list for Claim under PA Policy for Police Employees and Retired Personnel

1) Forwarding letter mentioning that the deceased Police personnel was under coverage of the policy at the time of accident.
2) PA Claim Form (National Insurance Company Ltd.) with Bank Account details of Legal Heir of the deceased duly filled by the legal heir and your office and original application of the legal heir.
3) Attested copy of incident report in detail.
4) Attested copy of investigation report.
5) Attested copy of FIR.
6) Attested copy of Command Certificate or Certificate to be issued by Head of the Unit about on or off duty.
7) Attested copy of Post Mortem Report.
8) Attested copy of Death Certificate.
9) Attested copy of Voter Identity Card of legal heir.
10) Attested copy of Aadhar Card of legal heir.
11) Attested copy of Aadhar Card or Voter Identity Card of the deceased.
12) **Filled up original Assignment Form for nominee verified by one DSP rank officer** of Dist./Unit with his name and seal or if Assignment Form is not filled up then i) legal heir certificate and ii) Original Affidavit issued by First Class Magistrate of the Court regarding no objection of other legal heir(s), if any.
13) Copy of a cancelled cheque of the claimant.
14) Receipt Copy of premium under P.A. policy for the policy period paid by Police personnel before his death and issued by your office

(पंजीकृत कार्यालय : 3, मिडिलटन स्ट्रीट, कलकत्ता-700 071)
(Regd. Office : 3, Middleton Street, Calcutta-700 071)

शारीरिक दुर्घटना दावा प्रपत्र
PERSONAL ACCIDENT INSURANCE CLAIM FORM

इस दावा प्रपत्र को भर कर कम्पनी के पॉलिसी जारी करने वाले कार्यालय को 7 दिन के अन्दर लौटाया जाना चाहिये। इस प्रपत्र को जारी करने से ही कम्पनी किसी दायित्व को स्वीकार नहीं करती है।

The completed claim form should be returned to the Policy Issuing Office of the Company within 7 days of its receipt.
The Company does not admit liability by issuing this form.

पॉलिसी संख्या
Policy No.

दावा संख्या
Claim No.

एजेन्सी कोड
Agency Code

1. बीमित का नाम (पूरा) Name of the Insured (in full)	
2. घायल व्यक्ति का नाम (व्यक्तिगत दुर्घटना पॉलिसी के विषय में) Name of the Injured (in case of Group Personal Accident Policy)	
3. बीमित / घायल व्यक्ति की आयु (अन्तिम जन्मदिवस) Age of the Insured / Injured Person (last birthday.)	
4. पूरा पता Address in Full	
5. बीमित / घायल व्यक्ति का व्यवसाय या पेशा Profession or Occupation of the Insured/Injured Person	

निम्नलिखित लिखें :
State the following :

(क) दुर्घटना की तिथि (a) Date of Accident	(ख) दुर्घटना का समय (b) Time of Accident	(ग) यह कहाँ हुई थी ? (c) Where it Happened ?

7. दुर्घटना किस प्रकार हुई थी ? State how did the accident occur ?	
8. चोटों के लिए बीमित/घायल व्यक्ति का पूर्ण विवरण दें। State as fully as you can the nature and extent of the injuries sustained ?	
9. इन चोटों के लिए बीमित / घायल व्यक्ति की परिचर्या करनेवाले डाक्टर / अस्पताल / नर्सिंग होम का नाम तथा पता दें। क्या अन्य चिकित्सक से परामर्श किया गया ? Give the name and the address of the Doctor / Hospital / Nursing Home where the Insured /the injured person for these injuries is being treated. Has any other Medical man been consulted ?	
10. चिकित्सा अधिकारी अथवा बीमा प्राधिकारियों द्वारा बीमित घायल व्यक्ति कब और कहाँ निरीक्षित (यदि आवश्यक हो) किया जा सकता है ? When and where can the Insured or the injured person be visited (if necessary) by a Medical Officer or an Official of the Company ?	
11. क्या बीमित / जीवन बीमाकृत दुर्घटना के समय पूर्ण स्वस्थ एवं शारीरिक दोष अथवा अशक्तता से मुक्त था ? Was the Insured / Injured Person in good health and free from physical defect or infirmity at the time of the accident ?	
12. क्या किसी अन्य व्यक्तिगत दुर्घटना बीमा के अन्तर्गत कोई दावा किया गया है यदि हाँ तो कृपया पॉलिसी संख्या के साथ में उसकी बीमा कम्पनी का नाम एवं पता लिखें। Is a claim being made under any other Personal Accident Insurance ? If so, please state the name and address of the insurance Company alongwith its Policy Number.	

घो ष णा

DECLARATION

मैं एतद्द्वारा घोषणा करता हूँ कि मेरे द्वारा दिये विवरण पूर्णतया सही है और मैंने किसी ऐसे तथ्य को छुपाया नहीं है जिसे सूचना कम्पनी को दी जानी चाहिये और मैं सहमत हूँ कि यदि मैंने किया है या किसी और सूचना जो कम्पनी मांगेगी, के असत्य या मिथ्या बयान करूं या कुछ छुपाऊं या असत्य बयान हो तो पॉलिसी निरस्त हो जायेगी और मेरा क्षतिपूर्ति का दावा रद्द हो जायेगा और मैं यदि आवश्यक हो, तो एक वैधानिक घोषणा को करने के लिए न्यायाधिकारी के समक्ष प्रस्तुत होने के तैयार हूँ।

I hereby declare that the foregoing statements are made by myself and are true in all respect a that I have not attempted to conceal from the Company anything with which it ought to be ma acquainted and I agree that if I have made, or in any further declaration the Company m require, shall make any false or fraudulent statement or any suppression, concealment or unt avertment whatever, the Policy shall be void, any my right to compensation forfeited, and I willing, if required, to make a Statutory Declaration before a Justice of the Peace of the tr of the whole of the foregoing statement or any other statement I may make in connection v this claim.

बीमित या घायल व्यक्ति के हस्ताक्षर

Signature of Insured or Injured P

तिथि :

Date :

गवाह :

Witness :

नाम Name	पता Address	हस्ताक्षर Signature

प्र० ई० बी० सुरक्षा-विमान प्रभाग कुट
—1 Pm. Call Curde (Ho. } A-0500

Govt. Compensation for Death /Disabled of Police personnel on duty

Check list for Govt. Compensation for Death /Disabled of Police personnel on duty

1. Original application of the claimant
2. Identity proof of the claimant
3. Legal heir Certificate
4. Incident Report
5. FIR/ Investigation Report
6. Post Mortem Report
7. Death Certificate
8. Command Certificate (for Police personnel)
9. Recommendation of District Magistrate- in case of election duty
10. Disabled Certificate issued by Medical Board- in case of disabled
11. Domicile Certificate – in case of Death of CPMF on duty
12. Recommendation of Nodal officer in terms of G.O. No. 3914 PL Dtd. 08.01.15- in case of Death of CPMF on duty

Police Salary Package for Police personnel

Forms

Annexure-I

The Branch Manager
State Bank of India
_____ Branch

Dear Sir,

POLICE SALARY PACKAGE – (1) REQUEST FOR CONVERSION OF SAVING BANK ACCOUNT TO PSP ACCOUNT AND (2) UNDERTAKING FROM ALL PSP ACCOUNT HOLDER, NEW & CONVERTED

1. I maintain a PSP SB account with your branch and the account number is _____ I intend to open a new PSP SB Account. I am presently employed as _____ with West Bengal Police Department, my ID number is _____and my date of birth is _____ (DD/MM/YYYY). My mobile number is _____. My present address is appended below which may please be incorporated in your records for which I am enclosing a certificate issued from the unit and request you to accept it for satisfying the KYC norms as prescribed by your bank, along with other document(s) as prescribed by the RBI.

2. In this connection I request that my existing account be converted into a Police Salary Package account with all its special features.

3 As regards converting my account to Savings Plus account: (Please tick in the appropriate box)

☐ **a.** I do not wish to avail of this facility **OR**

☐ **b.** I request you to convert my savings account into a Savings Plus account.

(if b, then the application is being submitted separately)

I confirm that I have read and understood the Terms and Conditions of Savings Plus Account. Payment of proceeds, as well as nomination for the term deposits so made would be as per my/ our Savings Plus Account with you, by debit to which the Multi Option Deposits would be created.

4. Since I am presently posted at / is being posted to _____ I request that my account should be transferred to _____ Branch of SBI for ease of operation.

5. I hereby undertake that I shall obtain a No Objection Certificate letter from SBI in case I desire to change to any other Bank for credit of salary. I further undertake that I shall not seek to change my salary bankers from SBI unless I have liquidated all loans outstanding with SBI.

Address: _____

_____

_____

Date:
Place:

Yours faithfully,
Signature
Name:
(With Rank and Decorations)
Mobile no-
Address:

Recommended

Signature

Seal of the Department Head/DDO

Annexure-II

The Branch Manager
State Bank of India
_____ Branch

Dear Sir,

POLICE SALARY PACKAGE – REQUEST FOR ISSUANCE OF NOC TO TRANSFER SALARY FROM PSP ACCOUNT WITH SBI TO ANOTHER BANK

1. I maintain a PSP SB account with your branch and the account number is _____/ I am presently employed as with West Bengal Police Department and my ID number is _____. My present address is _____
_____

2. I request you to issue me a No Objection Certificate as I desire to change my salary bank from where I draw my monthly salary i.e. SBI _____ Branch to _____ Bank for the following reason: _____
_____
_____

3. **I further declare that I have no loan(s) outstanding with SBI.**

Date:

Yours faithfully,

Place:

Name
(With Rank and Decorations)
Address:

To be submitted to the Home Branch Bank in duplicate and acknowledgement obtained from the Branch Manager/Authorized signatory of SBI on the second copy, duly stamped including date of receipt by the Bank and signature number of the Bank singnatory.

…….. ……

Annexure-III

The Branch Manager
State Bank of India
_____ Branch

Dear Sir,

REQUEST FOR OVERDRAFT IN SALARY ACCOUNT

1. I maintaining a (Salary Package) Savings Bank Account No. _____ with your branch. I confirm that I have received salary credits in aforementioned savings account for atleast past 6 consecutive months.

2. I request you to grant me an overdraft limit (facility) as under:

   Amount of Overdraft Required # : Rs. _____

   Net Monthly Salary : Rs. _____

   Tenor of Repayment : _____ months (Max 6 months)

   I am enclosing photocopy of my salary slips for your ready reference. The above loan is required to meet my urgent personal/domestic expenses.

   (# Maximum equivalent to two month net salary)

3. In consideration of your granting me the above facility, I agree.

   i. that interest on the amount of overdraft loan will be applied at the rate of .....% above 2 Yrs MCLR, the present effective rate of interest being .....% p.a. at monthly rest, provided that the Bank shall at any time, and from time to time be entitled to vary the spread/Base Rate at its discretion.

   ii. that the overdraft facility will operate on reducing drawing power basis, at monthly intervals, to the extent of the instalment commensurate with the tenor of the loan commencing from the month following the date of sanction of the facility. Interest when applied will be serviced every month. The liability to the Bank will be extinguished only when the outstanding in the Overdraft becomes Nil on payment of all instalment together with interest at the rate applicable.

4. I further undertake:

   i. that as a precondition to the overdraft advance granted to me by the Bank, I shall not withdraw/revoke the authority/instruction to my employer to credit my salary to the savings account with you, till liquidation of the overdraft with up-to-date interest.

   ii. to execute necessary authorization/documents, if any, as deemed just and necessary by the Bank in accordance with the scheme.

   iii. to pay the monthly instalment with interest on or before the due date, in case, my salary is ot credited to the above account for any reason whatsoever.

   iv. I shall obtain a No Objection Certificate latter from SBI in case I desire to change to any other Bank for credit of salary.

   v. I shall inform the Bank in event of my resignation, transfer, retirement, discontinuation of service.

5. In the event of delay/default in credit of monthly salary to the savings account, resulting in irregularity in the account, at any point of time, the Bank may send reminders and the entire incidental charge appurtenant thereto would be recovered from me/us.
6. I further agree that the Bank is at liberty to disclose/share my Credit information to/with Information Company formed under the Credit Information Company (Regulation) Act, 2005, as to the loans granted to me and any other manner which the RBI may consider necessary for inclusion I the Credit Information to be collected and maintained by Credit Information Companies and the Bank is not liable in any manner to me/us for providing the information as aforesaid to the Information Company

Yours faithfully,

(Applicant)
Name:
Address:
Date

फार्म डी. ए. – 1 / Form D.A. – 1

बैंक जमाओं के सम्बन्ध में बैं कग विनियम अधिनियम, 1949 की धारा 45 जेड ए तथा बैं कग कम्पनीज़ (नामांकन) नियम, 1985 के नियम 2(1) के अन्तर्गत नामांकन

Nomination under Section 45ZA of the Banking Regulation Act, 1949 and Rule 2(1) of the Banking Companies (Nomination) Rules, 1985 in respect of Bank Deposits.

मैं/हम

_____

(नाम और पता)

निम्नलिखित व्यक्ति का नामांकित करता/करत हूँ/करत हैं जिस मर /हमार /अवयस्क की मृत्यु हान पर उस जमा की राशि

_____

(उस शाखा/कायालय का नाम और पता जिसम राशि जमा है)

ारा लौटा द जाए जिसका विवरण न च दिया गया है

I/We _____

_____

(Name and addresses)

nominate the following persons to whom in the event of my/our minor's death the amount of the deposit, particulars whereof are given below, may be returned by _____

_____

(Name and address of the branch/office in which deposit held)

जमा/Deposit

प्रकार/Nature of	खाता क्र./Distinguish No.	अन्य विवरण, यदि काइ हा/Additional details, if any

नामित/Nominee

नाम Name	पता Address	जमाकता क साथ रश्ता, यदि काइ हा Relationship with depositor, if any	आयु Age	यदि नामिति अवयस्क हा ता, उसकी जन्म तिथि If Nominee is a minor, his/her date of birth

2. ** आज क दिन नामिति अवयस्क है, अत मैं/हम/श्र मत /कुमार _____

_____ का नामिति की अवयस्कता क दौरान

(नाम, पता और आयु)

मर /हमार /अवयस्क की मृत्यु हान पर उसकी आर स जमा की राशि प्राप्त करन क लिए नियुक्त करता/करत हूँ/करत हैं।

2. ** As the nominee is a minor on this date, I/We appoint Shri/Smt./Kum._____

_____

(Name, address and age)

to receive the amount of the deposit on behalf of the nominee in the event of my/our/minor's death during minority of the nominee.

स्थान/Place :
दिनांक/Date :

*जमाकता(ओं) क हस्ताक्षर/अंगूठा निशान
Signature(s)/Thumb Impression of depositor(s)

साक्षिया का नाम, हस्ताक्षर एवं पत @
Name(s), Signature(s) and
Address(es) of witness(es) @

_____

* जहाँ जमा किस अवयस्क व्यक्ति क नाम म हा वहाँ एस नामांकन पर उस व्यक्ति ारा हस्ताक्षर किय जान चाहिए जा कानून रूप स उस पर अवयस्क की आर स काय करन का हकदार हा।

* Where deposit is made in the name of minor, the nomination should be signed by a person lawfully entitled to act on the minor.

** यदि नामिति अवयस्क न हा ता काट द।

** Strike out if nominee is not a minor

Check List for claim under Police Salary Package of Police personnel

1) Filled up claim form as per proforma of United India Insurance Co. Ltd. (**Annexure-4) and (Annexure-5).**
2) Attested copy of Death Certificate.
3) Attested copy of FIR.
4) Attested copy of Post Mortem Report.
5) Certificate from Home Branch indicating the account of deceased as Salary Package operating account, along with variant, name of the nominee / joint account holder(s) as per Bank record **(Annexure-6).**
6) The application by the claimant containing details of his Account Number (i.e. Bank, Branch, Account No, MICR Code No, and IFS Code No.) along with cancelled cheque of his bank account for the purpose of NEFT payment of claim, for submission of **United India Insurance Co.** Ltd., as per (**Annexure-7) & (Annexure-8**).
7) Attested Copy of Aadhaar Card of Legal heir (.)
8) PAN card copy of the Claimant. If PAN card is not available, then form no. 60 (Filled up).
9) Other suitable document to prove legal case, if the claimant is not a joint account holder/no nominee as per Bank's record.
10) If nomination of deceased personnel is not registered in the SBI where the Salary Package Account is being maintained then (i) Legal heir certificate attested by First Class Magistrate ii) Original Affidavit for no objection of other legal heir(S) certificate issued by First Class Magistrate of the Court as per proforma of Insurance Company.

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UNITED INDIA INSURANCE CO. LTD

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020

Annexure 4

GROUP PERSONAL ACCIDENT/ AIR ACCIDENT CLAIM INTIMATION FORM

To be submitted for claiming Personal Accident Insurance (PAI) (death only) /Air Accident Insurance cover (AAI) (death only) on salary package account within 90 days after date of death of Salary Package Account holder of SBI

Issuance of this format for intimation of a claim is not to be taken as an admission of liability.

Policy No (A/c State Bank of India)		Fax No. : ..... Toll free Phone No. : ..... Email Id:
Policy Period	**04 .01.2019 to 03.01.2020**	

1	Name of Salary Account holder	
2	Address in full	
3	a) Date of Death	
	b) Date of Accident	
	c) Time of Accident	
	d) Place of Accident	
	e) Details of Accident	
4	Salary Package Account No.	
5	Type of Salary Package Account	# CSP/DSP/PMSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP
6	Variant of Salary Package A/C :	Silver Gold ☐ Diamond ☐ Platinum ☐
7	Name of the organization in case of DSP / PMSP / ICGSP	@ Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG
8	Personnel / Force number in case of DSP / PMSP / ICGSP	
9	Details of organization and	Name:

	Regiment/ Unit No. in case of DSP/PMSP/ICGSP	Address:
10	Details of SBI Branch where Salary Account is maintained	Name: Branch Code : Address:
11	Name of Nominee/Joint Account holder in the salary package account [If Available]	
12	Relationship of Nominee with Account Holder [If Available]	
13	Address of the Nominee (if available)	
14	E Mail ID of Nominee (if available)	
15	Contact Number of Nominee (if available)	

[#Corporate Salary Package (CSP), Defence Salary Package (DSP), Para Military Salary Package (PMSP), Indian Coast Guard Salary Package (ICGSP), State Government Salary Package (SGSP), Central Government Salary Package (CGSP), Police Salary Package (PSP) and Railway Salary Package (RSP), Start-up Salary Package (SUSP)]
(@ STRIKE OUT WHAT IS NOT APPLICABLE)

The foregoing details are true to the best of my / our knowledge and belief.

Signature of person Intimating Claim .....

Full Name of person Intimating Claim .....

Relationship with Deceased Account Holder .....

Contact details of person Intimating Claim
Landline No .....
Mobile No .....
Email ID .....

(Intimation may be advised through Email, Post, Telephone/ Fax)

UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020

Annexure 5

GROUP PERSONAL ACCIDENT/ AIR ACCIDENT CLAIM FORM

Submission of this format for claim is not to be taken as an admission of liability.

Policy No. **(State Bank of India)**		Fax No. : ..... Toll free Phone No. : .....
Policy Period	**04.01.2019 to 03.01.2020**	Email Id:

1	Name of Salary Account holder	
2	Address of Claimant	
3	a) Date of Death	
	b) Date of Accident	
	c) Time of Accident	
	d) Place of Accident	
	e) Details of Accident	
4	Salary Package Account No	
5	Type of Salary Package Account	# CSP/DSP/PMSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP
6	Variant of Salary Package A/C :	@ Silver/ Gold/ Diamond/ Platinum
7	Name of the organization in case of DSP / PMSP / ICGSP	@ Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG
8	Name of Nominee/Joint Account holder in the salary package account [If Available]	
9	Relationship of Nominee/ Joint Account holder with Account Holder [If Available]	

J	E Mail ID of Nominee (if available)	
11	Mobile Number of Nominee	
12	Details of SBI Branch where Salary Account is maintained	Branch Name: Code : Address:
13	Details of organization (Regiment/ Unit no. in case of DSP/PMSP/ICGSP also to be mentioned)	Name: Address:
14	Personnel / Force number in case of DSP / PMSP / ICGSP	
15	Claim Amount	PAI: (INR) AAI: (INR) Add on Covers: (INR)

Documents Submitted (Tick the box)			
Annexure 6 : Duly stamped and signed SBI Branch Manager's Certificate on Bank Letterhead		*Viscera Report / Chemical Analysis Report in case where post mortem report shows the cause of death due to poisoning or alcohol or confirm after Viscera/Chemical Analysis Report*	
Annexure 7 : *NEFT Form of Nominee/Joint Account /Claimant holder in the salary package account*		*Aadhar Card of Nominee/Joint Account holder /Claimant in the salary package account*	
Copy of Death Certificate		*PAN card copy of the Nominee/Joint Account holder/ Claimant in the salary package account. if not available, then form 60)*	
Copy of Post Mortem Report		*Photocopy of the first page of the Bank Passbook or Cheque containing the Name of Account Holder, IFSC Code of the Bank, Bank Account Number of Nominee/Joint Account holder/ Claimant*	
Copy of FIR Report		*Other suitable document to prove legal heir ship in case claimant is not a nominee / joint account holder as per Bank's record*	
Defence Authority report in case FIR is not available (For Armed forces)		*In case of multiple heirs, (consent from all the legal heirs)*	

I hereby declare that the foregoing statements made by me are true in all respects, that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Claim shall be void and my right to compensation forfeited. I am willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Signature of Nominee/Joint Account Holder/Claimant

Date .....

Annexure 6

(On Bank's Letter Head)
State Bank of India,

Branch Name : *Branch Code No:*
Address:
Email:----------
Telephone No: *Date:*

Policy No.:	*Policy Period 04.01.2019 to 03.01.2020*

This is to certify that Shri/Smt/Ms. who has expired on due to accident (as per the documents enclosed), is a holder of Salary Package Account, the details of which are as under:

1	Name of the Salary Package Account holder	:		
2	Address in full (as per Bank records)	:		
3	Date of Accidental Death (as per death certificate)	:		
4*	Details of SBI Branch where the Salary Package Account is maintained	:	*Name*	
			Code	
5	Type of Salary Package account DSP/PMSP/ICGSP/PSP/CSP/SGSP/CGSP/RSP	:		
6	Salary Package Account details :	:	*A/c No.*	
			Variant	*#Silver/ Gold/ Diamond/ Platinum*
7	Claim amount under Personal Accident/ Air Accident Insurance (Where Applicable)	:	*PAI*	*Rs.*
			AAI	*Rs.*
8	Nominee registered with the Bank on above mentioned Salary Package Account.(if any)	:		
	Address of Nominee	:		
	Phone No.	:		
9	Full name of Joint Account Holder(s) of the above mentioned Salary Package Account (for Joint Accounts)	:		
	Full Address of Joint Account Holder	:		
	Phone No.	:		

(# Strike out what is not applicable)

The Bank or its Officers will not be held responsible for the genuineness/authenticity of documents like FIR, Death Certificate, Post Mortem report, etc, being submitted by the claimant to the Insurance Company. It shall be the responsibility of the Insurance Company to ascertain their authenticity. All further correspondence should be made directly between the claimant and the Insurance Company. The claim settlement will be entirely the responsibility of Insurance Company. All settlements/disputes will be between the claimant and the Insurance Company and the Bank will not be a party to such disputes.

For State Bank of India,

(..... Branch)
Branch Manager
(SS No.)

NEFT FORM FOR PERSONAL ACCIDENT INSURANCE
(To be submitted by the claimant only)

UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No-01, 1st Floor, Sir V. T. Marg ,Mumbai -400 020 Email Id: vtsangtani@uiic.co.in

Annexure 7

Sir,

I/We furnish below details of my/our bank account to be used for effecting payments due to us by NEFT/RTGS

1.	**Registration for NEFT/RTGS payments**	
	Name of the Claimant (Account Holder)	
	Category	Personal Accident Insurance (Death) claim / Air Accident Insurance claim SBI Salary Package Account Holders
	Policy Number	
	Policy Period	
	Claim number, if any , provided (policyholders only)	
	Permanent Address	Address for Communication
2.	**Bank Account Details for NEFT/RTGS**	
	Name of account Holder/Claimant	
	Bank Name	
	Bank Branch Name	
	Bank Branch Address	
	MICR Code	
	Full Bank Account No. (for NEFT)	
	IFSC Code	

Please attach a copy of a cancelled cheque leaf or Photo copy of the first page of the Bank Pass Book containing the name of account holder, Bank account number, IFSC code. Please verify the details with your bank before submitting.

I/We hereby declare that the particulars given above are correct and express my/our willingness to receive credit of claim proceeds through the mode indicated above. Notwithstanding my/our choice of mode, United India Insurance Co. Ltd. reserves the right to issue a cheque/credit the account in the mode that may seem fit. I/We would not hold United Insurance Co. Ltd. responsible if the transaction is delayed or not effected at all or credited to an incorrect account for the reasons of incomplete/incorrect information.

Signature of the Applicant (Claimant)

Place:
Date:

UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020 Email Id: vtsangtani@uiic.co.in

Annexure 8

No. Dated:

Dear Sir/ Madam

CLAIM UNDER PERSONAL ACCIDENT INSURANCE (DEATH)/ AIR ACCIDENT (DEATH) COVER FOR SALARY PACKAGE ACCOUNT NO:
POLICY NO: VALID FROM TO
SALARY ACCOUNT HOLDER:
CLAIMANT: SHRI/SMT/Ms

We forward herewith an application for claim under Personal Accident Insurance (Death)/ Air Accident Insurance received from Shri/Smt/Ms..... Son/ Wife/Spouse of Shri/Smt/Ms ....., a Salary Package account holder with our branch under CSP/DSP/PMSP/ICGSP/RSP/SGSP/CGSP/PSP Start up, along with the following enclosures:

a) Claim form duly filled up
b) Copy of claim intimation (if available
c) Copy of Death Certificate.
d) Copy of police report and FIR. (For armed forces, Defence authority report in case FIR is not available)
e) Copy of Post Mortem Report
f) Certificate from the Bank together with the name of the nominee/ joint account holder, duly certified by the Bank officer with full address.
g) Pan Card copy /Form 60 of the claimant.
h) NEFT Form of the claimant, containing original cancelled cheque of the Bank account on the name of the claimant/ Photo copy of the first page of the Bank Pass Book containing the name of account holder, Bank account number, IFS code.
i) For Air Accident (Death) Insurance claim : Certified copy of Bank statement of Salary Package account indicating purchase of Air ticket/ payment to travel agent for purchase of Air ticket by debit to Salary Account using SBI Debit Card/ Internet Banking.

The application and above documents are being forwarded to you, without any responsibility of the Bank or its officers regarding their genuineness/ authenticity except item (f) above and it shall be the responsibility of the Insurance company to ascertain the authenticity of the relevant documents. However, for any clarification in this regard, please correspond directly with the claimant at the address mentioned in the claim form.

Yours faithfully,
Asst. General Manager/ Chief Manager/Branch Manager

Copy for information to:
(Name and address of nominee/ claimant).

The captioned claim with related annexure as mentioned above submitted by you have been forwarded to **United India Insurance Company Ltd.** at the recorded address. However, please note that all future correspondence in this regards should be taken up directly with the Insurance Company without involving the Bank. The Personal Accident (Death) Cover/ Air Accident Insurance cover, for Salary Package Account holders will be defined by the company as per the standard accidental death policies. The claim settlement will be entirely the responsibility of Insurance Company. All the settlement/ disputes will be between the claimant and the Insurance Company and the Bank will not be a party to such disputes.

Asst. General Manager/ Chief Manager/Branch Manager
(with stamp & seal of branch)

Copy for information and necessary action to:
Anand Rathi Insurance Brokers Ltd., Regent Chambers, 10th Floor, Jamanlal Bajaj Marg, Nariman Point, Mumbai 400021

Asst. General Manager/ Chief Manager/Branch Manager
(with stamp & seal of branch)

D. <u>ADDITIONAL DOCUMENTS FOR ADD ON COVER (Accidental Death)</u>

In addition to all documents applicable for submission of Personal Accident Insurance Claims,

i. Cost of Plastic Surgery / Burn (only for Gold, Diamond, Platinum)

a. Treating doctor's / Surgeon Certificate.
b. Original Discharge Summary containing all relevant details.
c. All original bills and their receipts.
d. Copies of all reports and prescriptions.
e. First prescription / consultation letter from the Doctor.
f. Original Money Receipt duly signed with revenue stamp.

ii. Transportation of Imported Medicine (only for Gold, Diamond, Platinum)

a. Medical Practitioner's prescription.
b. Copy of medicine invoice.
c. Invoice copy of freight expenses mentioning details of medicine imported, country of origin from which it is being imported, date and price of the medicine and freight expenses.

iii. Death after Coma after accident (more than 24 hrs.)

Medical certificate mentioning the duration of coma (start and end of coma period) supported by discharge summary and Indoor case papers.

iv. Air Ambulance – Maximum Rs. 5 Lakhs

a. Attending Doctor's advice / note with reason for shifting of the patient.
b. Original invoice and receipt for the Air Ambulance mentioning date of travel, sector (from/to place) and total amount.

v. Girl Child Cover:

a. Education fund Education (only Graduation) – 10% of PAI cover, maximum Rs.1 Lakh.

i. Copy of admission confirmation and certificate from educational institute stating details of full time course in a recognized college in India for Graduation along with duration of course and date of enrollment.
ii. Birth certificate of the Girl child.

b. Marriage expenses: (18-25 age)-10% of PAI cover, maximum Rs.1 Lakh

i. Birth certificate / Date of birth proof of girl child.
ii. document showing relationship with deceased Salary Account holder.

vi. Family Transportation – maximum Rs.20,000/- (cost of travel incurred by immediate 2 family members to reach place of accident)

a. Original bill receipt and travel ticket showing date of travel, Sector (from/to) and amount incurred.
b. Copy of proof of the immediate family member such as Ration Card.

vii. Repatriation of mortal remains – maximum Rs.10,000/-

Original Bill and receipt for transport of mortal remains, showing date and sector (From/to).

Annexure A

Claim Process for Personal Accidental Insurance SBI Gold/Yuva/Pride/Platinum/Premium/Signature Debit Card (Visa/MasterCard)

1. Policy No: **240700421910000081**
   (Please note: Policy number has to be mentioned on every communication to the insurance company.)
2. The claimant (s) has to submit *Personal Accident Insurance Intimation Form* **(Pages 2-3),** within 90 days from date of the accidental death of the Cardholder though speed/registered post/courier/by email/ by hand /tele-call:

   GLOBAL INSURANCE BROKERS PRIVATE LIMITED
   SHAUN D'SOUZA (ASSISTANT MANAGER - AFFINITY),
   5th FLOOR, ONE FORBES,
   DR. V.B. GANDHI MARG, NEAR KALAGHODA,
   FORT, MUMBAI – 400001 Tel. +9122 61845620 Board. +9122 66560505
   Fax: +9122 66560506 Mob: +91 9619943428
   Email Ids: claim.cards@globalinsurance.co.in / shaun.dsouza@globalinsurance.co.in / shaleen.trivedi@globalinsurance.co.in

   Additionally, mark Emails to NATIONAL INSURANCE COMPANY LIMITED.
   Email ID : Vinayak.Bhise@nic.co.in / 240700@nic.co.in/ RachanaK.Singh@nic.co.in

3. The claimant (s) has to submit the documents as per the *Documents Check List for Personal Accident Claim* **(Page-4)** along with Certificate from the Bank's Branch where the Cardholder's account is maintained, confirming death of the Cardholder, his Account No. and Debit Card No. **(Pages 7-8).**
4. The *Personal Accident Claim Form* **(Pages 5-6)** duly filled & signed by claimant in all respects should be submitted within 90 days from the date of death with the above address though speed/registered post/courier/by hand.
5. The claimant (s) will also have to submit *Bank Account Details* **(Page-9)** at the time of settlement of claim.
6. All correspondence shall be only between the claimant (s) and National Insurance Company Limited.
7. Detailed terms and conditions are provided on **Pages 10-11.**
8. Please note that all the documents submitted in regional language need to be translated to English to avoid delay in the settlement process.

Note: Insurance Company is not liable to cover SBI debit card variants which are not opted to cover by SBI under the Policy issued as per BIN list provided by SBI subject to admissibility under the policy.

Schedule I

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालयः विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,

सेक्टर 11, सी. बी. डी. बेलापूर, नवी मुंबई – 400 614

NATIONAL INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Belapur Branch : Vindhya Commercial Complex, 5th Floor, Plot No. 1,

Sector 11, CBD Belapur, Navi Mumbai – 400 614

Tel. 2757 5426/2757 9963 (D): 2756 0813 Fax: 2757 4342, website: www.nationalinsuranceindia.com

Email Ids: Vinayak.Bhise@nic.co.in / 240700@nic.co.in / RachanaK.Singh@nic.co.in

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Personal Accident Insurance Intimation Form on SBI Debit Card

This form is not to be taken as an admission of liability.

Date: _____

Place: _____

Policy No: 240700421910000081

1.	Name of SBI Debit Card Holder	
2.	Address of the Cardholder	
3.	Age of the Cardholder	
4.	SBI Debit Card No.	
5.	Type of SBI Debit Card	
6.	Account No.	
7.	Date of Accident	Date: Time:
	Date of Death	Date: Time:
	Where the accident did took place?	
	How did the accident occur?	
8.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :
9.	Personal Accident Insurance Cover Claim amount to the extent as applicable to the Card Variant (Air/Non-Air)	Rs.
10.	Name of Claimant	
11.	Full Address of Claimant	

12	Name of Person who intimate the claim	
13	Contact No (Compulsory)	
14	Email ID for Further Communication	

[Signature]

Schedule II

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालयः विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,
सेक्टर 11, सी. बी. डी. बेलापूर, नवी मुंबई – 400 614

NATIONAL INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Belapur Branch : Vindhya Commercial Complex, 5th Floor, Plot No. 1,
Sector 11, CBD Belapur, Navi Mumbai – 400 614

Tel. 2757 5426/2757 9963 (D): 2756 0813 Fax: 2757 4342, website: www.nationalinsuranceindia.com

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Documents Check List for Personal Accident Claim

Sr	Documents	
1.	Copy of claim intimation letter to be sent to National Insurance Company Limited	
2.	Claim form duly filled up.	
3.	Bank Certificate (Schedule	
4.	Bank Details of Claimant (Schedule	
5.	Certified copy of Police Report and F.I.R./ Panchnama.	
6.	Copy of Post Mortem (Autopsy Report as per PM report).	
7.	Medical Certificate from 1st attending Doctor in case of death after accidental hospitalization.	
8.	Original Death Certificate	
9.	Aadhar Card of the Cardholder	
10.	Affidavit from Legal Heir(s)	
11.	Original Debit Card	

Documents from serial no. 3 to 9 need to be duly attested by issuing authority or police authority official.

Schedule III

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालयः विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,

सेक्टर 11, सी. बी. डी. बेलापूर, नवी मुंबई – 400 614

NATIONAL INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Belapur Branch : Vindhya Commercial Complex, 5th Floor, Plot No. 1, Sector 11, CBD Belapur, Navi Mumbai – 400 614

Tel. 2757 5426/2757 9963 (D): 2756 0813 Fax: 2757 4342, website: www.nationalinsuranceindia.com

Email Ids: Vinayak.Bhise@nic.co.in / 240700@nic.co.in / RachanaK.Singh@nic.co.in

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Personal Accident Claim Form

If the Insured is unable to complete this form, it may be filled up on his behalf.
The Insurers do not admit liability by issuing this form

Policy No: 240700421910000081

Claim No: _____
(to be filled by National Insurance Company Limited)

1.	Name of SBI Debit Card Holder	
2.	Address of the Cardholder	
3.	Age of the Cardholder	
4.	SBI Debit Card No.	
5.	Type of SBI Debit Card	
6.	Account No.	
7.	Date of Accident	Date: Time:
	Date of Death	Date: Time:
	Where the accident did took place?	
	How did the accident occur?	
8.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :
9.	Personal Accident Insurance Cover to the extent as applicable to the Debit Card variant	Rs.

10.	Name of Claimant	
11.	Full Address of Claimant	
12	Contact No of Claimant (Compulsory)	
13	Email ID for Further Communication	

[Signature of Claimant]

Schedule IV

(On Bank's Letter Head)

SBI of India,
Branch Name: _____: Code No_____
Address: _____
Telephone No _____Fax No: _____
Email: _____@sbi.co.in

Ref No. _____ Date: _____

Policy No: 240700421910000081
Personal Accident Insurance Claim on SBI Debit Card
SBI Debit Card No._____

This is to certify that Shri/Smt/Ms_____ who has expired in an accident on_____ (as per the documents enclosed), is a SBI Debit Cardholder.

1.	Name of SBI Debit Cardholder			
2.	Address of the Cardholder (as per Bank's record)			
3.	SBI Debit Card No. with date of issuance			
4.	Type of SBI Debit Card (Tick applicable one)	Variant	VISA	MasterCard
		Gold		
		Platinum		
		Signature		
		Pride (Business Gold)		
		Premium (Business Platinum)		

		YUVA		
5.	Bank Account No.			
6.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :		
7.	Date of Accidental Death (as per death certificate)			
8.	Claim amount under Personal Accident Insurance as applicable	Rs.		
9.	Name of legal heir(s) (as per the affidavit)			
10.	Full Address of legal heir(s) (as per the affidavit)			

The Bank or its Officers will not be held responsible for the genuineness/ authenticity of other documents like FIR, Death Certificate, Post Mortem report, affidavit etc, being submitted by the claimant (s) to the Insurance Company.

Signature
(Branch Manager/Branch Head)

Schedule V

Date: _____
Place: _____

The Branch Manager,
National Insurance Company Limited,
Belapur Branch, Vindhya Commercial Complex,
5th Floor, Plot No. 1, Sector 11, CBD Belapur,
Navi Mumbai – 400 614
Tel. 022-2757 5426/2757 9963/2756 0813, Fax: 2757 4342

Bank Account Details:

(Mandatory to attach Cancelled cheque/Passbook 1st page copy)

Claimant (s) Name	
Claimant (s)'s Account No	
Claimant (s)'s Bank Name	
Claimant (s)'s Bank Branch Address	
Claimant (s)'s Bank IFSC Code	
MICR Code	
Type of Account	

Bank Stamp

Signature of the Claimant (s):

Date

Other Terms & Conditions

1) Personal Accidental Insurance: This insurance covers the Debit Cardholder for accidental death only, to the extent as applicable on the type of Debit Card held. This policy covers Accidental Death of the insured person occurred due to any bodily injury solely & directly from accident caused by external violent & visible means.
2) This Insurance Cover becomes operational when the Card is used at least once (on any channel, viz ATM/PoS/eCom during the last 90 days (**Successful Financial transaction)** from the date of accident.
3) In case of Death due to Air Accident, that Insurance Cover will only be available to the Cardholder subject to a condition that the air ticket should have been purchased by using the Debit Card.
4) The personal accident cover will be available for the beneficiaries in case of death in terrorist action/naxalite action and it will also cover death of Defense (Army/Navy/Air-Force)/Paramilitary/Police/Indian Coast Guard personnel on/off duty.
5) Insurance Company after receipt of the application will initiate the process of claim settlement. The insurance company will acknowledge the claim. All the correspondence related to claim will be directly taken up with the claimant (s) without involving Bank.
6) All the settlement/disputes will be between the claimant(s) and the insurance company and the Bank will not be a party to such disputes.
7) The claim settlement will be entirely the responsibility of the Insurance Company and Bank will have no liability towards any claim/dispute.
8) The insurance Company shall, on receipt of complete set of documents, process the claim. Any requirement/deficiencies in the documents submitted shall be sought within 15 working days of receipt of the claim. All the documents being in order, the Insurance Company will settle the claim within 30 working days from the date of receipt of last document. In case of delay beyond 30 days, the Insurance Company shall pay interest as per the IRDA regulations.
9) The claimant(s) has to submit Personal Accident Insurance Intimation Form (intimation letter) within 90 days of the accidental death of the Cardholder through speed post/registered post/courier/by hand.
10) The Personal Accident Claim Form duly filled in all respects with necessary document as per check list should be submitted within 90 days thereafter (i.e. period for intimation + claim = 90 days + 90 days = 180 days).
11) If the Debit Card holder is having more than one eligible Debit Card issued to him under one or more accounts, only one higher variant of the Debit Card will be considered for the claim purpose.
12) All claims where accident has occurred within the period of the policy and death has occurred, both (i) within the period of policy or (ii) after the expiry of policy shall be entertained by the Insurance Company. Further, as per IRDA guidelines, no claims should be rejected on account of delayed intimation and documents without ascertaining and recording the reasons for the said delay and satisfying themselves

that the claim would otherwise have been rejected even if it had been reported in time.

13) The beneficiary on death of eligible Debit Cardholder shall be as follows:
    a. Nominee, registered with the Bank for Savings Account in which the Debit Card has been issued in single name (Bank's role will be limited only to certify the name of nominee as per records of the Bank)
    b. In cases where the nominee's name is not available but the Savings Account in which the Debit Card is issued, is a joint account, then the beneficiary will be the surviving joint account holder(s) for the purpose of insurance claim. (Bank's role will be limited only to certify the names of surviving joint account holder(s) as per Bank records)
    c. In cases other than a) and b) above the claim shall be settled as per the procedure of insurer. The identification of legal heirs and the authenticity of the claim would be the responsibility of Insurer.

14) Any other supporting document/information, if required to deal with the claim would be asked for.

West Bengal Police Welfare & Sports Society
Enrollment Form

Form I

I _____(Name in full and rank) voluntarily agree to join the West Bengal Police Welfare and Sports Society after having read and fully understood the Objectives and Rules of the said Fund. I agree to pay membership fees of the Society. I further agree to accept any modifications in the rate of membership fees which Society may decide from time to time. I give my consent to the deduction from my pay the membership fees payable by me as per rules.

Signature of the applicant

Place : Name in full Father's name-
GPF Number -
Date : Rank : Post held :

Counter signature of DDO of the district/ Unit with date and seal :

Check list for Relief/Loan

A) Filled up Form-VII

Daughters/sons marriage:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Gross salary does not exceed Rs. 50,000/-
3. Age proof certificate (Bride/Groom).
4. Invitation card of marriage ceremony.

Self marriage:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Age proof certificate (Bride/Groom).
3. Invitation card of marriage ceremony.

Relief/ Medical loan:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Estimated cost of treatment with supporting documents.

Check list for Scholarship

B) Filled up Form-VIII

1. Membership under WBPWASS since July 17 or date of joining (for new employee).
2. Copy of Mark sheet/Grade Card (semester wise) and admit card issued from Board/University (Attested Copy).

Check list for Scholarship (Dying in Harness)

C) Filled up Form-VIII A

1. Death Certificate of employee.
2. Scholarship to be given to wards of Ex-Police Personnel (Dying in Harness cases waiting for employment under exempted category) from schooling to college education / post graduate /diploma.
3. Documents for paying annual fees etc. for two children of deceased.

Check list for Student Education Loan

D) Filled up Form-IX

1. Membership under WBPWASS since July 17 or date of joining (for new employee).
2. Annual fees must be Rs.50,000/- and above of said course.
3. Money receipt of current course from concerned University.

FORM VII

APPLICATION FOR GRANT OF RELIEF / LOAN FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:
2. Father's Name :
3. Rank:
4. Designation :
5. Place of Posting :
6. GPF no.
7. Present Basic Pay (with Grade pay):
8. Date of birth :
9. Whether member of West Bengal Police Welfare and Sports Society :
10. Purpose for which Relief/ Loan is required:

    (i) In case of serious sickness copies of medical documents showing the following should be enclosed –

    - Total expenditure on treatment-
    - Amount received from the WBHS -
    - Amount received from Medical Insurance policy (under WBP or personal policy)-
    - Amount required as help from West Bengal Police Welfare and Sports Society-

11. Details of last financial help given to the applicant from the Society and the purpose thereof :-

    (1). Loan sanctioned with date .

    (2). Loan amount paid.

    (3). Loan amount outstanding .

12. No. of persons dependent on the applicant :
13. Details of loan already taken from other sources, viz.

    Police Co-Operative, General Provident Fund, etc.

    and monthly deductions made from pay on that account. :

14. I hereby authorize deduction of loan installments every month from my pay in … . Installments of Rs
15. In the event of my retirement, discharge or dismissal or resignation, outstanding amount of loan, if any, is also hereby authorized to be deducted from my Government dues (including pay and allowances, General Provident Fund, Gratuity etc.)

Signature of the Applicant with date

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct .
2. Certified as per service book the name of Shri/ Smt.---------- exists as dependent on Shri/ Smt.---------- (the meaning of dependent will be same as per rules of Govt. of WB)

3. General remarks (to be filled in by verifying officer):
   4. Recommendations of the DSP/ SDPO/Additional SP/ SP :
   5. Recommendation of Chairman of the District /Unit Committee :
   6. Recommendation of the Chairman Zonal Committee :

Signature with date and seal of Head of office or officer authorized by him

* In case of dying in harness cases, the district head will send the death certificate and an application from the legal heir for writing off the loan. A separate application for financial aid needed for completion of education of dependent children or any other emergent cause may be sent to the Welfare Subcommittee through Zonal Committee.

FORM VIII

APPLICATION FOR GRANT OF SCHOLARSHIP FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:

2. Rank:

3. Designation :

4. Place of Posting :

5. GPF no.

6. Present Basic Pay (with Grade pay):

7. Whether member of West Bengal Police Welfare and Sports Society:

8. Name & age of the son/daughter for whom scholarship is prayed for :

9. (a) Name of the school/college/ Institution where admitted :

   (b) Class/M.P./H.S. or equivalent :

   Year of passing M.P./H.S./CBSE/ICSE/ISC :

   or other equivalent examination, school from

   which passed, Division and percentage of

   marks obtained (with attested copy of the

   mark-sheet and admit card)

10. 3 years degree course/ MBBS / Engineering// 5 years Law course :
    Post graduate studies / MBA/ any other course (d) Date of commencement and closing of the student's present academic session :

11. Semester wise mark sheet showing grade points :
    Issued by the College or University (attested copy)
    for students of Graduate and post graduate courses.

Date: Signature of the applicant

12. Recommendation of the District/Unit Committee:

13. Recommendation of the Chairman Zonal Committee :

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct.
2. Certified as per service book the name of Shri/ Smt.---------- exists

as dependent on Shri/ Smt.----------

- (the meaning of dependent will be same as per rules of Govt. of WB)

3. General remarks (to be filled in by verifying officer):

4. Recommendations of the DSP/ SDPO/Additional SP/ SP :

5. Recommendation of Chairman of the District Committee.

6. Recommendation of the Chairman of the Zonal Committee :

** Scholarships will be considered for students from the Academic Year 2018. (Students of class X and XII who have appeared in 2018 examination will be eligible to apply. Graduate and postgraduate students will be able to apply for scholarship as per eligibility criteria mentioned in the Rules – semester wise with effect from the Academic year beginning in summer of 2017.

FORM VIII A

APPLICATION FOR GRANT OF SPL. SCHOLARSHIP (DYING IN HARNESS) FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name of applicant:

2. Present Address:

3. Relation with deceased employee:

4. Name of deceased:

   (a) Date of death:

   (Attach attested copy of death certificate)

   (b) Rank & Designation at the time of death:

   (c) Last Place of Posting:

5. Present Gross Pension:

6. Whether employed under Exempted category:

   (Those who have already got job under exempted category & joined govt. duties are not eligible for this scholarship)

7. Name & age of the son/daughter for whom spl. scholarship is prayed for:

8. (a) Name of the school/college/ Institution where admitted:
   (Attach attested copy of admission slip issued by the institution)

   (b) Name of Class/course (Schooling to Graduation):

   (c) Period of Course:

   (d) Annual fees for the current academic session:

   (Attach Statement of course fees issued by the institution)

   (e) Fees already paid, if any:
   (Attach attested copy of Receipt of fees issued by the institution)

Date: Signature of the applicant

9. Recommendation of the District/Unit Committee:

10. Recommendation of the Chairman Zonal Committee:

FORM IX

APPLICATION FOR STUDENT EDUCATION LOAN FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:
2. Rank:
3. Designation :
4. Place of Posting :
5. GPF no.
6. Present Basic Pay (with Grade pay):
7. Date of birth :
8. Whether member of West Bengal Police Welfare and Sports Society:
9. Name of the son/ daughter :
10. Age :
11. (a) Name of the Institution/University/College where admitted :
12. Name and duration of the course :
13. Annual fees for the Course :
14. Details of last financial help given to the applicant and the purpose thereof:
15. No. of persons dependent on the applicant :
16. Details of loan already taken from other sources, viz. Police Co-Operative, General Provident Fund, etc. and monthly deductions made from pay on that account. :

17. I hereby authorize deduction of loan installments every month from my pay in .....installments of Rs.....

18. In the event of my retirement, discharge or dismissal, death, resignation, outstanding amount of loan, if any, is also hereby authorized to be deducted from my

Government dues (including pay and allowances, General Provident Fund, Gratuity etc.)

Signature of the Applicant with date

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct .
2. Certified as per service book the name of Shri/ Smt.---------- exists as dependent on Shri/ Smt.---------- (the meaning of dependent will be same as per rules of Govt. of WB).
3. General remarks (to be filled in by verifying officer):
4. Recommendations of the DSP/ SDPO/Additional SP/ SP :
5. Recommendation of the Chairman of the District Committee.
6. Recommendation of the Chairman of the Zonal Committee :

Signature with date and seal of Head of office or officer authorized by him

** Following shall be the eligibility conditions for application of student loan

1. Loan shall be deducted from salary in equal monthly installments.
2. DDO shall be responsible for deduction of loan from salary of the member and deposit to Society Fund.

West Bengal Health Scheme

Checklist for Reimbursement under West Bengal Health Scheme

Sl. No.	Name/Particulars of enclosures to be attached for Reimbursement Claim
1	Reimbursement Claim Form –C1/C2/C3/C4
2	Enrolment Certificate of Incumbent and beneficiary
3	Bill Summary of Indoor Treatment and OPD treatment sequentially
4	Original Bills / Money Receipts authenticated by the treating HCO
5	Copy of all prescriptions [for OPD and related OPD]
6	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate [for indoor treatment]
7	Copy of Form-H [for cashless indoor treatment]
8	Copy of Form-D4[for cashless indoor treatment]
9	Copy of all investigations/ tests report
10	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate d. Original Indemnity Bond on stamp paper [as per T.R. Form No. 14-Sec. Sub-rule(3) of T.R. 4.0841] with properly duly accepted by the unit / dist head himself. e. Enquiry report of legal heirs from local PS. f. Original application of the claimant
11	Original DDO certificate regarding admissible amount of the claim vide this office Org. No. 302(100)/Wel/Medl/20/2014 dt. 17/02/2014
12	Summary Sheet of claim vide No. 3737(2)/PL/HP/BMC/4C-119/15 dt. 20/11/15 of Pr. Secretary, Home & Hill and this office Org. No. 03/Wel/Medl-22/2016 dt. 13/01/2016
13	Original Tax / Invoice / Challan for implants, if any
14	Copy of permission [different type] required and granted, if any
15	Original prayer for condoning delay submission, if any.
16	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)
17	Duplicate set of all papers with the proposal

Note :

Form C1- for OPD treatment in empanelled HCO [with Annexure-I]

Form C2- for indoor treatment in non empanelled HCO [with Annexure-II]

Form C3- for indoor cashless treatment in empanelled HCO

Form C4- for indoor non-cashless treatment in non empanelled HCO

HCO- Health Care Organization.

All information available are in WWW.wbhealthscheme.gov.in

Manual/ Offline Reimbursement Application Form

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes ☐ No☐ Not known☐

3. Details of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details, If any		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in enlisted hospital outside West Bengal *(see clause 14 of order no.7287, dated 19.09.2008)*.	Memo No. : Date: Designation / Authority : U.O. No. and dateof Finance Deptt. West Bengal, if any:

Part-II [Details of Expenditure Statement of OPD treatment]

5. Details of OPD Treatment					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box)*[See list of diseases/illness mentioned in clause 7(1) and 7(2)]*	As per clause 7(1) of OPD List	☐	As per clause 7(2) of OPD List	☐
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. Expenditure Statement of OPD treatment		
Sl.	Name of Components	Amount

1

No.						Claimed (Rs.)
6.1	Consultation Fees					
6.2	Cost of Pathological and Radiological Investigations					
6.3	Cost of Medicines					
	Period of medicine consumption	From		To		
6.4	Cost of Special Device					
6.5	Miscellaneous (specify)					
					Total	
					No. of Vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. ;	In words; Rupees

Part-V [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Money Receipts in sequentially	Yes ☐	No ☐
4	Copy of OPD Prescription	Yes ☐	No ☐
5	Copy of permission granted if any	Yes ☐	No ☐
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
7	Copy of all investigation/ test reports in sequentially.	Yes ☐	No ☐

8	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
9	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
10	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
Name in Block Letters :
Designation/Last Designation :

Manual/ Offline Reimbursement Application Form

Form –C2

Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID *(To be filled at the time of online entry from end the Head of Office)*	

2. Detail of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Non-Empanelled/hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if Any (Tick mark in appropriate box)	Yes☐ No☐ Not known☐

3. Detail of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

Part-II [Details and Expenditure Statement of IPD treatment]

4. Period of treatment			
Admission Date		Discharge Date	

5. Type of Discharge					
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal	☐	5.3	Referral	☐
5.2	Risk Bond	☐	5.4	Death	☐

6. Amount Claimed for		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	☐
6.2	Only Non- Procedural/ Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	☐

6.1 Details of Procedural/ Package Treatment				
Period of Procedural/ Package Treatment		From		To
Sl. No	Name of Procedures/ Packages			Amount Claimed (Rs.)
6.1.1				
6.1.2				
6.1.3				
6.1.4				

1

6.1.5		
	Total	

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment						
Period of Non-Procedural/ Package Treatment		From		To		
Sl. No.	Name of Components					Amount Claimed (Rs.)
6.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
6.3.2	Consultation Fees					
6.3.3	Pathological and Radiological Investigations					
6.3.4	Medicines					
6.3.5	Consumables					
6.3.6	Special Nursing/Aya Charges					
6.3.7	Miscellaneous. (If Any Specify)					
	Total					
	No. of Vouchers					
	Total Treatment Cost [6.1+ 6.2+6.3]					

Net Claim:*(Part-II)*	
Rs. ;	In words; Rupees

Part-III [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl.	Name/Particulars of enclosures to be attached	Enclosed or not

Manual/ Offline Reimbursement Application Form

No.			
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent of a Non-Empanelled Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Bill Summary	Yes ☐	No ☐
4	Money Receipts in sequentially	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note and copy of death certificate	Yes ☐	No ☐
6	Detailed Bill	Yes ☐	No ☐
7	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
8	Copy of all investigation/ test reports in sequentially	Yes ☐	No ☐
9	Copy of OT Note in case of procedural/package treatment and treatment summary or bed head ticket in case of non-procedural/package treatment	Yes ☐	No ☐
10	In case of death of Employee, Pensioner and Family Pensioner; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No☐ No☐ No☐
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
12	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
Name in Block Letters :
Designation/Last Designation :

Form –C3

Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any				
2.1	Name of Patient			
2.2	Name of Empanelled/Enlisted hospital where treatment was availed			
2.3	Requirement of approval of delay Condonation, if any (Mark in appropriate box)	Yes ☐	No☐	Not known☐

3. Details of Claimant *(applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal*(see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Cashless Mode					
Sl. No.	Particulars			Details	
5.1	Transaction ID of Cashless Treatment *(See Form-H or D4 supplied by hospital at the time of discharge)*				
5.2	Treatment Period	Admission Date		Discharge Date	
5.3	Total Treatment Cost (Rs.)				
5.4	Cashless Admissible Reimbursement Certificate (CARC)No.				
5.5	Amount paid to hospital (Rs.)				
5.6	Amount admissible for reimbursement against CARC(Rs.) *(See Row no. 16 of CARC generated through system)*				
	Total Claim of Indoor Cashless Treatment (Rs.) *(amount mentioned in 5.6)*				
	Total nos. of Vouchers/Money Receipts				

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

6. Indoor related OPD treatment		
Do you want to claim Indoor related OPD treatment		

cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes** ☐	**No**☐

7. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

8. Details of Indoor related OPD treatment Expenditure						
Sl. No.	Name of Components					Amount Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Investigations					
8.3	Cost of Medicines					
	Period of medicine consumption	From		To		
8.4	Cost of Special Devices					
8.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of Vouchers					

Part-IV [Medical Advance]

9. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

10. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus Part-V]*	
Rs. ;	In words; Rupees

Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrollment Certificate of beneficiary	Yes ☐	No ☐
2	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes ☐	No ☐
3	Money Receipts of both Indoor and OPD treatment sequentially	Yes ☐	No ☐
4	Copy of related OPD Prescriptions sequentially (if claimed)	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes☐	No ☐
6	Copy of Form-H	Yes ☐	No☐
7	Copy of Form-D4	Yes ☐	No☐
8	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes ☐	No☐
9	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
10	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
11	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant :
Name in Block Letters :
Designation/Last Designation :

Form –C4

Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed	
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes ☐ No ☐ Not known ☐

3. Details of Claimant *(applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal[*see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:
4.2	For treatment availed in enlisted hospital outside West Bengal *(see clause 14 of Order No.7287, dated 19.09.2008*).	Memo No. : Date: Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Reimbursement Mode(If No is selected in Sl. No 3)				
Period of treatment	Admission Date		Discharge date	

6. Type of Discharge					
Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal	☐	6.3	Referral	☐
6.2	Risk Bond	☐	6.4	Death	☐

7.Amount Claimed for		
Sl. No.	Type of Treatment	(Tick mark in appropriate box)
6.1	Only Procedural/ Package Treatment	☐

1

6.2	Only Non- Procedural/ Non-Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	☐

7.1 Details of Procedural/ Package Treatment

Period of Procedural/ Package Treatment		From		To	
Sl.No.	Name of Procedures/ Packages		Procedure Code	Amount Claimed(Rs.)	
7.1.1					
7.1.2					
7.1.3					
7.1.4					
7.1.5					
			Total		

7.2 Details of Implants Used

Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.

Period of Non-Procedural/ Non-Package Treatment.		From		To	
Sl. No.	Name of Component				Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent				
	ICCU/ITU/ICU/NICU/PICU	From		To	
	HDU/SDU	From		To	
	Burn Unit	From		To	
	CRIB	From		To	
	General/Semi-Private/Private	From		To	
7.3.2	Consultation Fees.				
7.3.3	Pathological and Radiological Investigations.				
7.3.4	Medicines.				
7.3.5	Consumables				
7.3.6	Special Nursing/Aya Charges				
7.3.7	Miscellaneous. (If any specify)				
	Total Claim of Reimbursement Mode of Treatment(Rs.) (amount mentioned in 7.1+ 7.2+7.3)				
	No. of vouchers				

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

8. Indoor related OPD treatment

Do you want to claim Indoor related OPD treatment cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes** ☐	**No**☐

9. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

10. Details of Indoor related OPD treatment Expenditure						
Sl. No.	Name of Components					Amount Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Investigations					
10.3	Cost of Medicines					
	Period of medicine consumption	From		To		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of vouchers					

Part-IV [Medical Advance]

12. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

13. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus V]*	
Rs. ;	In words; Rupees

Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrollment Certificate of beneficiary	Yes ☐	No ☐
2	Bill Summary of Indoor Treatment and OPD treatment	Yes ☐	No ☐
3	Money Receipts of both Indoor and OPD treatment in sequence manner (In chronological order)	Yes ☐	No ☐
4	Copy of related OPD Prescriptions (if claimed)	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes☐	No ☐
5	Copy of permission granted if any	Yes ☐	No☐
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011	Yes ☐	No☐
8	Copy of Detailed Bill of Indoor Treatment	Yes ☐	No ☐
9	Original copy of Voucher/ Tax Invoice/Challan of Implants	Yes ☐	No ☐
10	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment sequentially	Yes ☐	No ☐
11	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes☐	 No☐ No ☐ No ☐
12	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes☐	No ☐
13	Any other instruments (Specify)	Yes ☐	No☐

Date:

Signature of the Employee/Pensioner/Claimant :
Name in Block Letters :
Designation/Last Designation :

Annexure-I

Certification of Treating Specialist of **Empanelled Hospital** for claiming reimbursement of **"Out Patient Department"** treatment under WBHS

1. Certified that the patient, Sri/Smt._____ is a beneficiary of West Bengal Health Scheme having the Beneficiary ID is_____.

2. S/he has been suffering from_____(specify name of disease) as listed in Sl. No._____ of the OPD list as per 7(1) clause or follow-up medical attendance and treatment of _____ as per 7(2) clause of order number 7287-F, dated 19/09/2008 issued by Medical Cell, Finance Department, Government of West Bengal.

Date:

Signature of the Treating Specialist
Registration No: .....
Registering Authority:.....
Present Degree: .....
..... Hospital

Official Seal of Treating Hospital

List of OPD (Out-Patient Department) Diseases

As per clause 7(1) of 7287–F, dated; 19-09-2008				As per clause 7(2) of 7287–F, dated; 19-09-2008	
Sl. No	**Name of Disease**	**Sl. No**	**Name of Disease**	**Sl. No**	**Name of Disease**
1	Malignant Diseases.	10	Injuries Caused by Accident (including Animal Bite).	1	Neuro Surgery.
2	Tuberculosis.	11	Rheumatoid Arthritis.	2	Cardiac Surgery (Including Coronary Angioplasty and implants).
3	Hepatitis B/C and Other Liver Diseases.	12	Systematic Lupus Erytthematous (LUPUS).	3	Cancer Surgery/ Chemotherapy/ Radiotherapy.
4	Insulin Dependent Diabetes (Type-2 Diabetic Mellitus is not considered as Insulin Dependent Diabetes).	13	Crohn's Disease.	4	Renal Transplant.
5	Heart Diseases.	14	Endodontic Treatment (Root Canal Treatment).	5	Hip/ Knee replacement Surgery.
6	Neurological Disorder/ Cerebra vascular Disorders.	15	COPD (Chronic Obstructive Pulmonary Disease).	6	Accident cases.
7	Malignant Malaria.	16	Ankylosing Spondylitis		
8	Renal Failure.	17	None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]		
9	Thallasaemia/ Bleeding orders/ Platelet Disorders.				

Annexure-II

Certification of Medical Superintendent/ Administrative Officer and Treating Specialist of treating in **Non-Empanelled Hospital** for claiming reimbursement of only **"Indoor"** treatment under WBHS

1. Certified that the patient, Sri/Smt._____ is a beneficiary of West Bengal Health Scheme having the Beneficiary ID is_____ availed indoor treatment from _____ to _____.
2. Certified that the Hospital/Nursing Home/Health Care Organisation has _____ ( ) nos. of bed.
3. Certified that the Hospital/Nursing Home/Health Care Organisation obtained a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____ and this License is valid up to _____.

Date:

Signature of Medical Superintendent
..... Hospital
Official Seal of the Hospital

West Bengal Police Medical Insurance Policy
Enrollment Form

FORM – A

Data of members in excel file format for enrolment under West Bengal Police Medical Insurance Policy issued by National Insurance Co. & TPA Genins India TPA Lt. for the year.....
Maximum **4 persons** are allowed on 1 (Self) +1 (Spouse) + 2 (Son(s) / Daughter (s) / Brother(s)/Sister(s)

*1. **I want to take policy by paying premium of Rs...../-***

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Wife/Husband			F/M		
3	GINI060				Son/Daughter			M/F		
4	GINI060				Daughter/Son			F/M		
5	GINI060				Brother/ Sister			M/F		
6	GINI060				Sister/ Brother			F/M		

Signature of the Primary member

Address :

FORM – B

Data of members in excel file format for enrolment under West Bengal Police Medical Insurance Policy issued by National Insurance Co. & TPA Genins India TPA Lt. for the year.....

Maximum 6 persons are allowed on 1 (Self) +1 (Spouse) + 2 (Son(s) / Daughter (s) / Brother(s)/Sister(s)+2 Either Parents or In-laws

*1. **I want to take policy by paying premium of Rs...../-***

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID **(name of year)**	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Wife/Husband			F/M		
3	GINI060				Son/Daughter			M/F		
4	GINI060				Daughter/Son			F/M		
5	GINI060				Brother/ Sister			M/F		
6	GINI060				Sister/ Brother			F/M		
7	GINI060				Father			M		
8	GINI060				Mother			F		
9	GINI060				Father-in-law			M		
10	GINI060				Mother-in-law			F		

Signature of the Primary member

Address :

FORM - C

For Retired Police Personnel

I want to become Member of West Bengal Police Medical Insurance Policy by paying premium of Rs...../-. **for the year.....**

Sl No	Last Year Genins Card ID No. **(name of year)**	PPO NO.	Pension Sanctioning Authority	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**					**SELF**			**M/F**		
2	**GINI060**					Wife/Husband			F/M		
3	GINI060					Handicapped Son/Daughter			M/F		
4	GINI060					Handicapped Daughter/Son			F/M		

Signatures of the Primary member

Address :

FORM – D

For Family Pension Holders (Aged upto 60 years)

I want to become Member of West Bengal Police Mediclaim Policy by paying premium of Rs...../-. **for the year.....**

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relationship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	**GINI060**				**SELF**			**M/F**		
2	GINI060				Son/Daughter			M/F		
3	GINI060				Daughter/Son			F/M		

Signature of the Primary member

Address :

FORM – E

For Family Pension Holders (Aged 60 years above)

I want to become Member of West Bengal Police Mediclaim Policy by paying premium of Rs...../-. **for the year.....**

(Please strike out any one which is not applicable)

Sl No	Last Year Genins Card ID (name of year)	GPF NO.	Rank	Member's Name	Relatio n-ship	Date of Birth	Age	Gender	Telephone No.	Remarks
1	GINI060				SELF			M/F		

Signature of the Primary member

Address :

Check list for Reimbursement under Mediclaim Policy for Police Employees

All reimbursement claims to be submitted to the office of TPA through their sector representative(s) with the following documents:

- ✓ Filled up Claim Form mentioning claim amount, ID Card No., GPF No., Phone No., Bank Account No., Name of Branch of Bank and IFS Code No.
- ✓ IRDA guided claim Form "Part-B"
- ✓ Advice for admission/ Emergency Admission Note.
- ✓ Discharge Certificate.
- ✓ Discharge Certificate/ Day Care Certificate and all Bills Vouchers in case of Day Care Treatment.
- ✓ Final Bills with break up and Numbered money receipt & cash memo for Doctor's Fees.
- ✓ Prescription / Medicine Bills / Pathological test reports.
- ✓ Implant Sticker / Tax in voice.
- ✓ Prescription / Medicine Bills / Pathological test reports etc. for treatment of 30 days pre hospitalisation and 60 days post hospitalisation.
- ✓ MLC copy/ FIR copy/ Self declaration in case of accident.
- ✓ Prescription/ Discharge Certificate/ Final Bill/ Recommendation of Unit Head through Police Directorate for Buffer Claim.
- ✓ All papers to be submitted in original.

Personal Accident Policy for Police Employees and Retired Personnel

Enrollment Form

Declaration for PA Claim

Assignment (applicable when proposal is for own life)

I have taken PA Policy issued by National Insurance Company Limited by paying premium of Rs...../-

I..... (Name and Brass no of the Police Personnel / Ministerial Staff / Employee) do hereby assign the moneys payable in the event of my death by National Insurance Company Limited to ..... (Name of the person to receive compensation) who is my ..... (relation with the member) and I further declare that his/her receipt shall be sufficient to discharge the Company.

Place..... Date ..... Signature of the Proposer

Assignment witnessed by

Sl. No.	Name	Address	Signature

Name, Rank and Signature along-with official seal of the person verifying this proposal

(Officer of D. S. P. and above rank must sign this form)

Declaration for PA Claim

Assignment (applicable when proposal is for own life)

I have taken PA Policy issued by National Insurance Company Limited by paying premium of Rs...../-

I..... (Name and PPO No of the Retired Police Officer) do hereby assign the moneys payable in the event of my death by National Insurance Company Limited to ..... (Name of the person to receive compensation) who is my ..... (relation with the member) and I further declare that his/her receipt shall be sufficient to discharge the Company.

Place..... Date ..... Signature of the Proposer

Assignment witnessed by

Sl. No.	Name	Address	Signature

Name, Rank and Signature along-with official seal of the person verifying this proposal

(Officer of D. S. P. and above rank must sign this form)

Check list for Claim under PA Policy for Police Employees and Retired Personnel

1) Forwarding letter mentioning that the deceased Police personnel was under coverage of the policy at the time of accident.
2) PA Claim Form (National Insurance Company Ltd.) with Bank Account details of Legal Heir of the deceased duly filled by the legal heir and your office and original application of the legal heir.
3) Attested copy of incident report in detail.
4) Attested copy of investigation report.
5) Attested copy of FIR.
6) Attested copy of Command Certificate or Certificate to be issued by Head of the Unit about on or off duty.
7) Attested copy of Post Mortem Report.
8) Attested copy of Death Certificate.
9) Attested copy of Voter Identity Card of legal heir.
10) Attested copy of Aadhar Card of legal heir.
11) Attested copy of Aadhar Card or Voter Identity Card of the deceased.
12) **Filled up original Assignment Form for nominee verified by one DSP rank officer** of Dist./Unit with his name and seal or if Assignment Form is not filled up then i) legal heir certificate and ii) Original Affidavit issued by First Class Magistrate of the Court regarding no objection of other legal heir(s), if any.
13) Copy of a cancelled cheque of the claimant.
14) Receipt Copy of premium under P.A. policy for the policy period paid by Police personnel before his death and issued by your office

(पंजीकृत कार्यालय : 3, मिडिलटन स्ट्रीट, कलकत्ता-700 071)
(Regd. Office : 3, Middleton Street, Calcutta-700 071)

शारीरिक दुर्घटना दावा प्रपत्र
PERSONAL ACCIDENT INSURANCE CLAIM FORM

इस दावा प्रपत्र को भर कर कम्पनी के पॉलिसी जारी करने वाले कार्यालय को 7 दिन के अन्दर लौटाया जाना चाहिये। इस प्रपत्र को जारी करने से ही कम्पनी किसी दायित्व को स्वीकार नहीं करती है।

The completed claim form should be returned to the Policy Issuing Office of the Company within 7 days of its receipt.
The Company does not admit liability by issuing this form.

पॉलिसी संख्या
Policy No.

दावा संख्या
Claim No.

एजेन्सी कोड
Agency Code

1. बीमित का नाम (पूरा) Name of the Insured (in full)	
2. घायल व्यक्ति का नाम (व्यक्तिगत दुर्घटना पॉलिसी के विषय में) Name of the Injured (in case of Group Personal Accident Policy)	
3. बीमित / घायल व्यक्ति की आयु (अन्तिम जन्मदिवस) Age of the Insured / Injured Person (last birthday.)	
4. पूरा पता Address in Full	
5. बीमित / घायल वक्ति का व्यवसाय या पेशा Profession or Occupation of the Insured/Injured Person	

निम्नलिखित लिखें :
State the following :

(क) दुर्घटना की तिथि (a) Date of Accident	(ख) दुर्घटना का समय (b) Time of Accident	(ग) यह कहाँ हुई थी ? (c) Where it Happened ?

7. दुर्घटना किस प्रकार हुई थी ? State how did the accident occur ?	
8. चोटों के लिए बीमित/घायल व्यक्ति का पूर्ण विवरण दें। State as fully as you can the nature and extent of the injuries sustained ?	
9. इन चोटों के लिए बीमित / घायल व्यक्ति की परिचर्या करनेवाले डाक्टर / अस्पताल / नर्सिंग होम का नाम तथा पता दें। क्या अन्य चिकित्सक से परामर्श किया गया ? Give the name and the address of the Doctor / Hospital / Nursing Home where the Insured /the injured person for these injuries is being treated. Has any other Medical man been consulted ?	
10. चिकित्सा अधिकारी अथवा बीमा प्राधिकारियों द्वारा बीमित घायल व्यक्ति कब और कहाँ निरीक्षित (यदि आवश्यक हो) किया जा सकता है ? When and where can the Insured or the injured person be visited (If necessary) by a Medical Officer or an Official of the Company ?	
11. क्या बीमित / जीवन बीमाकृत दुर्घटना के समय पूर्ण स्वस्थ एवं शारीरिक दोष अथवा अशक्तता से मुक्त था ? Was the Insured / Injured Person in good health and free from physical defect or infirmity at the time of the accident ?	
12. क्या किसी अन्य व्यक्तिगत दुर्घटना बीमा के अन्तर्गत कोई दावा किया गया है यदि हाँ तो कृपया पॉलिसी संख्या के साथ में उसकी बीमा कम्पनी का नाम एवं पता लिखें। Is a claim being made under any other Personal Accident Insurance ? If so, please state the name and address of the insurance Company alongwith its Policy Number.	

घोषणा

DECLARATION

मैं एतद्द्वारा घोषणा करता हूँ कि मेरे द्वारा दिये विवरण पूर्णतया सही है और मैंने किसी ऐसे तथ्य को छुपाया नहीं है जिसे सूचना कम्पनी को दी जानी चाहिये और मैं सहमत हूँ कि यदि मैंने किया है या किसी और सूचना जो कम्पनी मांगेगी, के असत्य या मिथ्या बयान करूं या कुछ छुपाऊं या असत्य बयान हो तो पॉलिसी निरस्त हो जायेगी और मेरा क्षतिपूर्ति का दावा रद्द हो जायेगा और मैं यदि आवश्यक हो, तो एक वैधानिक घोषणा को करने के लिए न्यायाधिकारी के समक्ष प्रस्तुत होने के तैयार हूँ।

I hereby declare that the foregoing statements are made by myself and are true in all respect a that I have not attempted to conceal from the Company anything with which it ought to be ma acquainted and I agree that if I have made, or in any further declaration the Company m require, shall make any false or fraudulent statement or any suppression, concealment or unt avertment whatever, the Policy shall be void, any my right to compensation forfeited, and I willing, if required, to make a Statutory Declaration before a Justice of the Peace of the tr of the whole of the foregoing statement or any other statement I may make in connection v this claim.

बीमित या घायल व्यक्ति के हस्ताक्षर

Signature of Insured or Injured P

तिथि :

Date :

गवाह :

Witness :

नाम Name	पता Address	हस्ताक्षर Signature

प्र० हे० कार्य-सूचना-विभाग प्रपत्र कूट — 1 Pm. Call Circle Inv. } A-0500

Govt. Compensation for Death /Disabled of Police personnel on duty

Check list for Govt. Compensation for Death /Disabled of Police personnel on duty

1. Original application of the claimant
2. Identity proof of the claimant
3. Legal heir Certificate
4. Incident Report
5. FIR/ Investigation Report
6. Post Mortem Report
7. Death Certificate
8. Command Certificate (for Police personnel)
9. Recommendation of District Magistrate- in case of election duty
10. Disabled Certificate issued by Medical Board- in case of disabled
11. Domicile Certificate – in case of Death of CPMF on duty
12. Recommendation of Nodal officer in terms of G.O. No. 3914 PL Dtd. 08.01.15- in case of Death of CPMF on duty

Police Salary Package for Police personnel

Forms

Annexure-I

The Branch Manager
State Bank of India
_____ Branch

Dear Sir,

POLICE SALARY PACKAGE – (1) REQUEST FOR CONVERSION OF SAVING BANK ACCOUNT TO PSP ACCOUNT AND (2) UNDERTAKING FROM ALL PSP ACCOUNT HOLDER, NEW & CONVERTED

1. I maintain a PSP SB account with your branch and the account number is _____ I intend to open a new PSP SB Account. I am presently employed as _____ with West Bengal Police Department, my ID number is _____and my date of birth is _____ (DD/MM/YYYY). My mobile number is _____. My present address is appended below which may please be incorporated in your records for which I am enclosing a certificate issued from the unit and request you to accept it for satisfying the KYC norms as prescribed by your bank, along with other document(s) as prescribed by the RBI.

2. In this connection I request that my existing account be converted into a Police Salary Package account with all its special features.

3 As regards converting my account to Savings Plus account: (Please tick in the appropriate box)

☐ **a.** I do not wish to avail of this facility **OR**

☐ **b.** I request you to convert my savings account into a Savings Plus account.

(if b, then the application is being submitted separately)

I confirm that I have read and understood the Terms and Conditions of Savings Plus Account. Payment of proceeds, as well as nomination for the term deposits so made would be as per my/ our Savings Plus Account with you, by debit to which the Multi Option Deposits would be created.

4. Since I am presently posted at / is being posted to _____ I request that my account should be transferred to _____ Branch of SBI for ease of operation.

5. I hereby undertake that I shall obtain a No Objection Certificate letter from SBI in case I desire to change to any other Bank for credit of salary. I further undertake that I shall not seek to change my salary bankers from SBI unless I have liquidated all loans outstanding with SBI.

Address: _____

_____

_____

Date:
Place:

Yours faithfully,
Signature
Name:
(With Rank and Decorations)
Mobile no-
Address:

Recommended

Signature
Seal of the Department Head/DDO

Annexure-II

The Branch Manager
State Bank of India
_____ Branch

Dear Sir,

POLICE SALARY PACKAGE – REQUEST FOR ISSUANCE OF NOC TO TRANSFER SALARY FROM PSP ACCOUNT WITH SBI TO ANOTHER BANK

1. I maintain a PSP SB account with your branch and the account number is _____/ I am presently employed as with West Bengal Police Department and my ID number is _____. My present address is _____
_____

2. I request you to issue me a No Objection Certificate as I desire to change my salary bank from where I draw my monthly salary i.e. SBI _____ Branch to _____ Bank for the following reason: _____
_____
_____

3. **I further declare that I have no loan(s) outstanding with SBI.**

Date: Yours faithfully,

Place: Name
(With Rank and Decorations)
Address:

To be submitted to the Home Branch Bank in duplicate and acknowledgement obtained from the Branch Manager/Authorized signatory of SBI on the second copy, duly stamped including date of receipt by the Bank and signature number of the Bank singnatory.

…….. ……

Annexure-III

The Branch Manager

State Bank of India
_____ Branch

Dear Sir,

REQUEST FOR OVERDRAFT IN SALARY ACCOUNT

1. I maintaining a (Salary Package) Savings Bank Account No. _____ with your branch. I confirm that I have received salary credits in aforementioned savings account for atleast past 6 consecutive months.

2. I request you to grant me an overdraft limit (facility) as under:

   Amount of Overdraft Required # : Rs. _____

   Net Monthly Salary : Rs. _____

   Tenor of Repayment : _____ months (Max 6 months)

   I am enclosing photocopy of my salary slips for your ready reference. The above loan is required to meet my urgent personal/domestic expenses.

   (# Maximum equivalent to two month net salary)

3. In consideration of your granting me the above facility, I agree.

   i. that interest on the amount of overdraft loan will be applied at the rate of .....% above 2 Yrs MCLR, the present effective rate of interest being .....% p.a. at monthly rest, provided that the Bank shall at any time, and from time to time be entitled to vary the spread/Base Rate at its discretion.

   ii. that the overdraft facility will operate on reducing drawing power basis, at monthly intervals, to the extent of the instalment commensurate with the tenor of the loan commencing from the month following the date of sanction of the facility. Interest when applied will be serviced every month. The liability to the Bank will be extinguished only when the outstanding in the Overdraft becomes Nil on payment of all instalment together with interest at the rate applicable.

4. I further undertake:

   i. that as a precondition to the overdraft advance granted to me by the Bank, I shall not withdraw/revoke the authority/instruction to my employer to credit my salary to the savings account with you, till liquidation of the overdraft with up-to-date interest.

   ii. to execute necessary authorization/documents, if any, as deemed just and necessary by the Bank in accordance with the scheme.

   iii. to pay the monthly instalment with interest on or before the due date, in case, my salary is ot credited to the above account for any reason whatsoever.

   iv. I shall obtain a No Objection Certificate latter from SBI in case I desire to change to any other Bank for credit of salary.

   v. I shall inform the Bank in event of my resignation, transfer, retirement, discontinuation of service.

5. In the event of delay/default in credit of monthly salary to the savings account, resulting in irregularity in the account, at any point of time, the Bank may send reminders and the entire incidental charge appurtenant thereto would be recovered from me/us.
6. I further agree that the Bank is at liberty to disclose/share my Credit information to/with Information Company formed under the Credit Information Company (Regulation) Act, 2005, as to the loans granted to me and any other manner which the RBI may consider necessary for inclusion I the Credit Information to be collected and maintained by Credit Information Companies and the Bank is not liable in any manner to me/us for providing the information as aforesaid to the Information Company

Yours faithfully,

(Applicant)
Name:
Address:
Date

फार्म डी. ए. – 1 / Form D.A. – 1

बैंक जमाओं के सम्बन्ध में बैं कग विनियम अधिनियम, 1949 की धारा 45 जेड ए तथा बैं कग कम्पनीज़ (नामांकन) नियम, 1985 के नियम 2(1) के अन्तर्गत नामांकन

Nomination under Section 45ZA of the Banking Regulation Act, 1949 and Rule 2(1) of the Banking Companies (Nomination) Rules, 1985 in respect of Bank Deposits.

मैं/हम

_____

(नाम और पता)

निम्नलिखित व्यक्ति का नामांकित करता/करत हूँ/करत हैं जिस मर /हमार /अवयस्क की मृत्यु हान पर उस जमा की राशि

_____

(उस शाखा/कायालय का नाम और पता जिसम राशि जमा है)

ारा लौटा द जाए जिसका विवरण न च दिया गया है

I/We _____

_____

(Name and addresses)

nominate the following persons to whom in the event of my/our minor's death the amount of the deposit, particulars whereof are given below, may be returned by _____

_____

(Name and address of the branch/office in which deposit held)

जमा/Deposit

प्रकार/Nature of	खाता क्र./Distinguish No.	अन्य विवरण, यदि काइ हा/Additional details, if any

नामित/Nominee

नाम Name	पता Address	जमाकता क साथ रश्ता, यदि काइ हा Relationship with depositor, if any	आयु Age	यदि नामिति अवयस्क हा ता, उसकी जन्म तिथि If Nominee is a minor, his/her date of birth

2. ** आज क दिन नामिति अवयस्क है, अत मैं/हम/श्र मत /कुमार _____

_____ का नामिति की अवयस्कता क दौरान

(नाम, पता और आयु)

मर /हमार /अवयस्क की मृत्यु हान पर उसकी आर स जमा की राशि प्राप्त करन क लिए नियुक्त करता/करत हूँ/करत हैं।

2. ** As the nominee is a minor on this date, I/We appoint Shri/Smt./Kum._____

_____

(Name, address and age)

to receive the amount of the deposit on behalf of the nominee in the event of my/our/minor's death during minority of the nominee.

स्थान/Place :

दिनांक/Date :

साक्षिया का नाम, हस्ताक्षर एवं पत @

Name(s), Signature(s) and

Address(es) of witness(es) @

*जमाकता(आं) क हस्ताक्षर/अंगूठा निशान

Signature(s)/Thumb Impression of depositor(s)

* जहाँ जमा किस अवयस्क व्यक्ति क नाम म हा वहाँ एस नामांकन पर उस व्यक्ति ारा हस्ताक्षर किय जान चाहिए जा कानून रूप स उस पर अवयस्क की आर स काय करन का हकदार हा।

* Where deposit is made in the name of minor, the nomination should be signed by a person lawfully entitled to act on the minor.

** यदि नामिति अवयस्क न हा ता काट द।

** Strike out if nominee is not a minor

@ अंगूठा-निशान दा साक्षिया ारा अनुप्रमाणित किय जायग।

@ Thumb Impression(s) shall be attested by two witnesses.

Check List for claim under Police Salary Package of Police personnel

1) Filled up claim form as per proforma of United India Insurance Co. Ltd. (**Annexure-4) and (Annexure-5).**
2) Attested copy of Death Certificate.
3) Attested copy of FIR.
4) Attested copy of Post Mortem Report.
5) Certificate from Home Branch indicating the account of deceased as Salary Package operating account, along with variant, name of the nominee / joint account holder(s) as per Bank record **(Annexure-6).**
6) The application by the claimant containing details of his Account Number (i.e. Bank, Branch, Account No, MICR Code No, and IFS Code No.) along with cancelled cheque of his bank account for the purpose of NEFT payment of claim, for submission of **United India Insurance Co.** Ltd., as per (**Annexure-7) & (Annexure-8**).
7) Attested Copy of Aadhaar Card of Legal heir (.)
8) PAN card copy of the Claimant. If PAN card is not available, then form no. 60 (Filled up).
9) Other suitable document to prove legal case, if the claimant is not a joint account holder/no nominee as per Bank's record.
10) If nomination of deceased personnel is not registered in the SBI where the Salary Package Account is being maintained then (i) Legal heir certificate attested by First Class Magistrate ii) Original Affidavit for no objection of other legal heir(S) certificate issued by First Class Magistrate of the Court as per proforma of Insurance Company.

UNITED INDIA INSURANCE CO. LTD

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020

Annexure 4

GROUP PERSONAL ACCIDENT/ AIR ACCIDENT CLAIM INTIMATION FORM

To be submitted for claiming Personal Accident Insurance (PAI) (death only) /Air Accident Insurance cover (AAI) (death only) on salary package account within 90 days after date of death of Salary Package Account holder of SBI

Issuance of this format for intimation of a claim is not to be taken as an admission of liability.

Policy No (A/c State Bank of India)		Fax No. : ..... Toll free Phone No. : ..... Email Id:
Policy Period	**04 .01.2019 to 03.01.2020**	

1	Name of Salary Account holder	
2	Address in full	
3	a) Date of Death	
	b) Date of Accident	
	c) Time of Accident	
	d) Place of Accident	
	e) Details of Accident	
4	Salary Package Account No.	
5	Type of Salary Package Account	# CSP/DSP/PMSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP
6	Variant of Salary Package A/C :	Silver Gold ☐ Diamond ☐ Platinum ☐
7	Name of the organization in case of DSP / PMSP / ICGSP	@ Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG
8	Personnel / Force number in case of DSP / PMSP / ICGSP	
9	Details of organization and	Name:

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	Regiment/ Unit No. in case of DSP/PMSP/ICGSP	Address:
10	Details of SBI Branch where Salary Account is maintained	Name: Branch Code : Address:
11	Name of Nominee/Joint Account holder in the salary package account [If Available]	
12	Relationship of Nominee with Account Holder [If Available]	
13	Address of the Nominee (if available)	
14	E Mail ID of Nominee (if available)	
15	Contact Number of Nominee (if available)	

[#Corporate Salary Package (CSP), Defence Salary Package (DSP), Para Military Salary Package (PMSP), Indian Coast Guard Salary Package (ICGSP), State Government Salary Package (SGSP), Central Government Salary Package (CGSP), Police Salary Package (PSP) and Railway Salary Package (RSP), Start-up Salary Package (SUSP)]
(@ STRIKE OUT WHAT IS NOT APPLICABLE)

The foregoing details are true to the best of my / our knowledge and belief.

Signature of person Intimating Claim .....

Full Name of person Intimating Claim .....

Relationship with Deceased Account Holder .....

Contact details of person Intimating Claim
Landline No .....
Mobile No .....
Email ID .....

(Intimation may be advised through Email, Post, Telephone/ Fax)

UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020

Annexure 5

GROUP PERSONAL ACCIDENT/ AIR ACCIDENT CLAIM FORM

Submission of this format for claim is not to be taken as an admission of liability.

Policy No. **(State Bank of India)**		Fax No. : ..... Toll free Phone No. : .....
Policy Period	**04.01.2019 to 03.01.2020**	Email Id:

1	Name of Salary Account holder	
2	Address of Claimant	
3	a) Date of Death	
	b) Date of Accident	
	c) Time of Accident	
	d) Place of Accident	
	e) Details of Accident	
4	Salary Package Account No	
5	Type of Salary Package Account	# CSP/DSP/PMSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP
6	Variant of Salary Package A/C :	@ Silver/ Gold/ Diamond/ Platinum
7	Name of the organization in case of DSP / PMSP / ICGSP	@ Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG
8	Name of Nominee/Joint Account holder in the salary package account [If Available]	
9	Relationship of Nominee/ Joint Account holder with Account Holder [If Available]	

J	E Mail ID of Nominee (if available)	
11	Mobile Number of Nominee	
12	Details of SBI Branch where Salary Account is maintained	Branch Name: Code : Address:
13	Details of organization (Regiment/ Unit no. in case of DSP/PMSP/ICGSP also to be mentioned)	Name: Address:
14	Personnel / Force number in case of DSP / PMSP / ICGSP	
15	Claim Amount	PAI: (INR) AAI: (INR) Add on Covers: (INR)

Documents Submitted (Tick the box)			
Annexure 6 : Duly stamped and signed SBI Branch Manager's Certificate on Bank Letterhead		*Viscera Report / Chemical Analysis Report in case where post mortem report shows the cause of death due to poisoning or alcohol or confirm after Viscera/Chemical Analysis Report*	
Annexure 7 : *NEFT Form of Nominee/Joint Account /Claimant holder in the salary package account*		*Aadhar Card of Nominee/Joint Account holder /Claimant in the salary package account*	
Copy of Death Certificate		*PAN card copy of the Nominee/Joint Account holder/ Claimant in the salary package account. if not available, then form 60)*	
Copy of Post Mortem Report		*Photocopy of the first page of the Bank Passbook or Cheque containing the Name of Account Holder, IFSC Code of the Bank, Bank Account Number of Nominee/Joint Account holder/ Claimant*	
Copy of FIR Report		*Other suitable document to prove legal heir ship in case claimant is not a nominee / joint account holder as per Bank's record*	
Defence Authority report in case FIR is not available (For Armed forces)		*In case of multiple heirs, (consent from all the legal heirs)*	

I hereby declare that the foregoing statements made by me are true in all respects, that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Claim shall be void and my right to compensation forfeited. I am willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Signature of Nominee/Joint Account Holder/Claimant

Date .....

Annexure 6

(On Bank's Letter Head)
State Bank of India,

Branch Name : *Branch Code No:*
Address:
Email:----------
Telephone No: *Date:*

Policy No.:	*Policy Period 04.01.2019 to 03.01.2020*

This is to certify that Shri/Smt/Ms. who has expired on due to accident (as per the documents enclosed), is a holder of Salary Package Account, the details of which are as under:

1	Name of the Salary Package Account holder	:		
2	Address in full (as per Bank records)	:		
3	Date of Accidental Death (as per death certificate)	:		
4*	Details of SBI Branch where the Salary Package Account is maintained	:	*Name*	
			Code	
5	Type of Salary Package account DSP/PMSP/ICGSP/PSP/CSP/SGSP/CGSP/RSP	:		
6	Salary Package Account details :	:	*A/c No.*	
			Variant	*#Silver/ Gold/ Diamond/ Platinum*
7	Claim amount under Personal Accident/ Air Accident Insurance (Where Applicable)	:	*PAI*	*Rs.*
			AAI	*Rs.*
8	Nominee registered with the Bank on above mentioned Salary Package Account.(if any)	:		
	Address of Nominee	:		
	Phone No.	:		
9	Full name of Joint Account Holder(s) of the above mentioned Salary Package Account (for Joint Accounts)	:		
	Full Address of Joint Account Holder	:		
	Phone No.	:		

(# Strike out what is not applicable)

The Bank or its Officers will not be held responsible for the genuineness/authenticity of documents like FIR, Death Certificate, Post Mortem report, etc, being submitted by the claimant to the Insurance Company. It shall be the responsibility of the Insurance Company to ascertain their authenticity. All further correspondence should be made directly between the claimant and the Insurance Company. The claim settlement will be entirely the responsibility of Insurance Company. All settlements/disputes will be between the claimant and the Insurance Company and the Bank will not be a party to such disputes.

For State Bank of India,

(..... Branch)
Branch Manager
(SS No.)

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NEFT FORM FOR PERSONAL ACCIDENT INSURANCE
(To be submitted by the claimant only)

UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No-01, 1st Floor, Sir V. T. Marg ,Mumbai -400 020 Email Id: vtsangtani@uiic.co.in

Annexure 7

Sir,

I/We furnish below details of my/our bank account to be used for effecting payments due to us by NEFT/RTGS

1.	**Registration for NEFT/RTGS payments**	
	Name of the Claimant (Account Holder)	
	Category	Personal Accident Insurance (Death) claim / Air Accident Insurance claim SBI Salary Package Account Holders
	Policy Number	
	Policy Period	
	Claim number, if any , provided (policyholders only)	
	Permanent Address	Address for Communication
2.	**Bank Account Details for NEFT/RTGS**	
	Name of account Holder/Claimant	
	Bank Name	
	Bank Branch Name	
	Bank Branch Address	
	MICR Code	
	Full Bank Account No. (for NEFT)	
	IFSC Code	

Please attach a copy of a cancelled cheque leaf or Photo copy of the first page of the Bank Pass Book containing the name of account holder, Bank account number, IFSC code. Please verify the details with your bank before submitting.

I/We hereby declare that the particulars given above are correct and express my/our willingness to receive credit of claim proceeds through the mode indicated above. Notwithstanding my/our choice of mode, United India Insurance Co. Ltd. reserves the right to issue a cheque/credit the account in the mode that may seem fit. I/We would not hold United Insurance Co. Ltd. responsible if the transaction is delayed or not effected at all or credited to an incorrect account for the reasons of incomplete/incorrect information.

Signature of the Applicant (Claimant)

Place:
Date:

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UNITED INDIA INSURANCE CO. LTD.

DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020 Email Id: vtsangtani@uiic.co.in

Annexure 8

No. Dated:

Dear Sir/ Madam

CLAIM UNDER PERSONAL ACCIDENT INSURANCE (DEATH)/ AIR ACCIDENT (DEATH) COVER FOR SALARY PACKAGE ACCOUNT NO:
POLICY NO: VALID FROM TO
SALARY ACCOUNT HOLDER:
CLAIMANT: SHRI/SMT/Ms

We forward herewith an application for claim under Personal Accident Insurance (Death)/ Air Accident Insurance received from Shri/Smt/Ms..... Son/ Wife/Spouse of Shri/Smt/Ms ....., a Salary Package account holder with our branch under CSP/DSP/PMSP/ICGSP/RSP/SGSP/CGSP/PSP Start up, along with the following enclosures:

a) Claim form duly filled up
b) Copy of claim intimation (if available
c) Copy of Death Certificate.
d) Copy of police report and FIR. (For armed forces, Defence authority report in case FIR is not available)
e) Copy of Post Mortem Report
f) Certificate from the Bank together with the name of the nominee/ joint account holder, duly certified by the Bank officer with full address.
g) Pan Card copy /Form 60 of the claimant.
h) NEFT Form of the claimant, containing original cancelled cheque of the Bank account on the name of the claimant/ Photo copy of the first page of the Bank Pass Book containing the name of account holder, Bank account number, IFS code.
i) For Air Accident (Death) Insurance claim : Certified copy of Bank statement of Salary Package account indicating purchase of Air ticket/ payment to travel agent for purchase of Air ticket by debit to Salary Account using SBI Debit Card/ Internet Banking.

The application and above documents are being forwarded to you, without any responsibility of the Bank or its officers regarding their genuineness/ authenticity except item (f) above and it shall be the responsibility of the Insurance company to ascertain the authenticity of the relevant documents. However, for any clarification in this regard, please correspond directly with the claimant at the address mentioned in the claim form.

Yours faithfully,
Asst. General Manager/ Chief Manager/Branch Manager

Copy for information to:
(Name and address of nominee/ claimant).

The captioned claim with related annexure as mentioned above submitted by you have been forwarded to **United India Insurance Company Ltd.** at the recorded address. However, please note that all future correspondence in this regards should be taken up directly with the Insurance Company without involving the Bank. The Personal Accident (Death) Cover/ Air Accident Insurance cover, for Salary Package Account holders will be defined by the company as per the standard accidental death policies. The claim settlement will be entirely the responsibility of Insurance Company. All the settlement/ disputes will be between the claimant and the Insurance Company and the Bank will not be a party to such disputes.

Asst. General Manager/ Chief Manager/Branch Manager
(with stamp & seal of branch)

Copy for information and necessary action to:
Anand Rathi Insurance Brokers Ltd., Regent Chambers, 10th Floor, Jamanlal Bajaj Marg, Nariman Point, Mumbai 400021

Asst. General Manager/ Chief Manager/Branch Manager
(with stamp & seal of branch)

D. ADDITIONAL DOCUMENTS FOR ADD ON COVER (Accidental Death)

In addition to all documents applicable for submission of Personal Accident Insurance Claims,

i. Cost of Plastic Surgery / Burn (only for Gold, Diamond, Platinum)

a. Treating doctor's / Surgeon Certificate.
b. Original Discharge Summary containing all relevant details.
c. All original bills and their receipts.
d. Copies of all reports and prescriptions.
e. First prescription / consultation letter from the Doctor.
f. Original Money Receipt duly signed with revenue stamp.

ii. Transportation of Imported Medicine (only for Gold, Diamond, Platinum)

a. Medical Practitioner's prescription.
b. Copy of medicine invoice.
c. Invoice copy of freight expenses mentioning details of medicine imported, country of origin from which it is being imported, date and price of the medicine and freight expenses.

iii. Death after Coma after accident (more than 24 hrs.)

Medical certificate mentioning the duration of coma (start and end of coma period) supported by discharge summary and Indoor case papers.

iv. Air Ambulance – Maximum Rs. 5 Lakhs

a. Attending Doctor's advice / note with reason for shifting of the patient.
b. Original invoice and receipt for the Air Ambulance mentioning date of travel, sector (from/to place) and total amount.

v. Girl Child Cover:

a. Education fund Education (only Graduation) – 10% of PAI cover, maximum Rs.1 Lakh.

i. Copy of admission confirmation and certificate from educational institute stating details of full time course in a recognized college in India for Graduation along with duration of course and date of enrollment.
ii. Birth certificate of the Girl child.

b. Marriage expenses: (18-25 age)-10% of PAI cover, maximum Rs.1 Lakh

i. Birth certificate / Date of birth proof of girl child.
ii. document showing relationship with deceased Salary Account holder.

vi. Family Transportation – maximum Rs.20,000/- (cost of travel incurred by immediate 2 family members to reach place of accident)

a. Original bill receipt and travel ticket showing date of travel, Sector (from/to) and amount incurred.
b. Copy of proof of the immediate family member such as Ration Card.

vii. Repatriation of mortal remains – maximum Rs.10,000/-

Original Bill and receipt for transport of mortal remains, showing date and sector (From/to).

Annexure A

Claim Process for Personal Accidental Insurance SBI Gold/Yuva/Pride/Platinum/Premium/Signature Debit Card (Visa/MasterCard)

1. Policy No: **240700421910000081**
   (Please note: Policy number has to be mentioned on every communication to the insurance company.)
2. The claimant (s) has to submit *Personal Accident Insurance Intimation Form* **(Pages 2-3),** within 90 days from date of the accidental death of the Cardholder though speed/registered post/courier/by email/ by hand /tele-call:

   GLOBAL INSURANCE BROKERS PRIVATE LIMITED
   SHAUN D'SOUZA (ASSISTANT MANAGER - AFFINITY),
   5th FLOOR, ONE FORBES,
   DR. V.B. GANDHI MARG, NEAR KALAGHODA,
   FORT, MUMBAI – 400001 Tel. +9122 61845620 Board. +9122 66560505
   Fax: +9122 66560506 Mob: +91 9619943428
   Email Ids: claim.cards@globalinsurance.co.in / shaun.dsouza@globalinsurance.co.in / shaleen.trivedi@globalinsurance.co.in

   Additionally, mark Emails to NATIONAL INSURANCE COMPANY LIMITED.
   Email ID : Vinayak.Bhise@nic.co.in / 240700@nic.co.in/ RachanaK.Singh@nic.co.in

3. The claimant (s) has to submit the documents as per the *Documents Check List for Personal Accident Claim* **(Page-4)** along with Certificate from the Bank's Branch where the Cardholder's account is maintained, confirming death of the Cardholder, his Account No. and Debit Card No. **(Pages 7-8).**
4. The *Personal Accident Claim Form* **(Pages 5-6)** duly filled & signed by claimant in all respects should be submitted within 90 days from the date of death with the above address though speed/registered post/courier/by hand.
5. The claimant (s) will also have to submit *Bank Account Details* **(Page-9)** at the time of settlement of claim.
6. All correspondence shall be only between the claimant (s) and National Insurance Company Limited.
7. Detailed terms and conditions are provided on **Pages 10-11.**
8. Please note that all the documents submitted in regional language need to be translated to English to avoid delay in the settlement process.

Note: Insurance Company is not liable to cover SBI debit card variants which are not opted to cover by SBI under the Policy issued as per BIN list provided by SBI subject to admissibility under the policy.

Schedule I

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालय: विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,

सेक्टर 11, सी. बी. डी. बेलापूर, नवी मुंबई – 400 614

NATIONAL INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Belapur Branch : Vindhya Commercial Complex, 5th Floor, Plot No. 1,

Sector 11, CBD Belapur, Navi Mumbai – 400 614

Tel. 2757 5426/2757 9963 (D): 2756 0813 Fax: 2757 4342, website: www.nationalinsuranceindia.com

Email Ids: Vinayak.Bhise@nic.co.in / 240700@nic.co.in / RachanaK.Singh@nic.co.in

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Personal Accident Insurance Intimation Form on SBI Debit Card

This form is not to be taken as an admission of liability.

Date: _____

Place: _____

Policy No: 240700421910000081

1.	Name of SBI Debit Card Holder	
2.	Address of the Cardholder	
3.	Age of the Cardholder	
4.	SBI Debit Card No.	
5.	Type of SBI Debit Card	
6.	Account No.	
7.	Date of Accident	Date: Time:
	Date of Death	Date: Time:
	Where the accident did took place?	
	How did the accident occur?	
8.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :
9.	Personal Accident Insurance Cover Claim amount to the extent as applicable to the Card Variant (Air/Non-Air)	Rs.
10.	Name of Claimant	
11.	Full Address of Claimant	

12	Name of Person who intimate the claim	
13	Contact No (Compulsory)	
14	Email ID for Further Communication	

[Signature]

Schedule II

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालयः विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,
सेक्टर 11, सी. बी. डी. बेलापूर, नवी मुंबई – 400 614

NATIONAL INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Belapur Branch : Vindhya Commercial Complex, 5th Floor, Plot No. 1,
Sector 11, CBD Belapur, Navi Mumbai – 400 614

Tel. 2757 5426/2757 9963 (D): 2756 0813 Fax: 2757 4342, website: www.nationalinsuranceindia.com

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Documents Check List for Personal Accident Claim

Sr	Documents	
1.	Copy of claim intimation letter to be sent to National Insurance Company Limited	
2.	Claim form duly filled up.	
3.	Bank Certificate (Schedule	
4.	Bank Details of Claimant (Schedule	
5.	Certified copy of Police Report and F.I.R./ Panchnama.	
6.	Copy of Post Mortem (Autopsy Report as per PM report).	
7.	Medical Certificate from 1st attending Doctor in case of death after accidental hospitalization.	
8.	Original Death Certificate	
9.	Aadhar Card of the Cardholder	
10.	Affidavit from Legal Heir(s)	
11.	Original Debit Card	

Documents from serial no. 3 to 9 need to be duly attested by issuing authority or police authority official.

Schedule III

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

बेलापूर मण्डल कार्यालयः विंध्या कमर्शियल काम्पलेक्स, 5वी मंजिल, प्लाट क्र. 1,

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Email Ids: Vinayak.Bhise@nic.co.in / 240700@nic.co.in / RachanaK.Singh@nic.co.in

(Registered & Head Office: 3, Middleton Street, Kolkata – 700 071)

Personal Accident Claim Form

If the Insured is unable to complete this form, it may be filled up on his behalf.
The Insurers do not admit liability by issuing this form

Policy No: 240700421910000081

Claim No: _____
(to be filled by National Insurance Company Limited)

1.	Name of SBI Debit Card Holder	
2.	Address of the Cardholder	
3.	Age of the Cardholder	
4.	SBI Debit Card No.	
5.	Type of SBI Debit Card	
6.	Account No.	
7.	Date of Accident	Date: Time:
	Date of Death	Date: Time:
	Where the accident did took place?	
	How did the accident occur?	
8.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :
9.	Personal Accident Insurance Cover to the extent as applicable to the Debit Card variant	Rs.

10.	Name of Claimant	
11.	Full Address of Claimant	
12	Contact No of Claimant (Compulsory)	
13	Email ID for Further Communication	

[Signature of Claimant]

Schedule IV

(On Bank's Letter Head)

SBI of India,
Branch Name: _____: Code No_____
Address: _____
Telephone No _____Fax No: _____
Email: _____@sbi.co.in

Ref No. _____ Date: _____

Policy No: 240700421910000081
Personal Accident Insurance Claim on SBI Debit Card
SBI Debit Card No. _____

This is to certify that Shri/Smt/Ms_____ who has expired in an accident on_____ (as per the documents enclosed), is a SBI Debit Cardholder.

1.	Name of SBI Debit Cardholder			
2.	Address of the Cardholder (as per Bank's record)			
3.	SBI Debit Card No. with date of issuance			
4.	Type of SBI Debit Card (Tick applicable one)	Variant	VISA	MasterCard
		Gold		
		Platinum		
		Signature		
		Pride (Business Gold)		
		Premium (Business Platinum)		

		YUVA		
5.	Bank Account No.			
6.	Name of the SBI Branch and Branch Code where the Cardholder's account is maintained	Branch Name : Branch Code :		
7.	Date of Accidental Death (as per death certificate)			
8.	Claim amount under Personal Accident Insurance as applicable	Rs.		
9.	Name of legal heir(s) (as per the affidavit)			
10.	Full Address of legal heir(s) (as per the affidavit)			

The Bank or its Officers will not be held responsible for the genuineness/ authenticity of other documents like FIR, Death Certificate, Post Mortem report, affidavit etc, being submitted by the claimant (s) to the Insurance Company.

Signature
(Branch Manager/Branch Head)

Schedule V

Date: _____
Place: _____

The Branch Manager,
National Insurance Company Limited,
Belapur Branch, Vindhya Commercial Complex,
5th Floor, Plot No. 1, Sector 11, CBD Belapur,
Navi Mumbai – 400 614
Tel. 022-2757 5426/2757 9963/2756 0813, Fax: 2757 4342

Bank Account Details:

(Mandatory to attach Cancelled cheque/Passbook 1st page copy)

Claimant (s) Name	
Claimant (s)'s Account No	
Claimant (s)'s Bank Name	
Claimant (s)'s Bank Branch Address	
Claimant (s)'s Bank IFSC Code	
MICR Code	
Type of Account	

Bank Stamp

Signature of the Claimant (s):

Date

Other Terms & Conditions

1) Personal Accidental Insurance: This insurance covers the Debit Cardholder for accidental death only, to the extent as applicable on the type of Debit Card held. This policy covers Accidental Death of the insured person occurred due to any bodily injury solely & directly from accident caused by external violent & visible means.
2) This Insurance Cover becomes operational when the Card is used at least once (on any channel, viz ATM/PoS/eCom during the last 90 days (**Successful Financial transaction)** from the date of accident.
3) In case of Death due to Air Accident, that Insurance Cover will only be available to the Cardholder subject to a condition that the air ticket should have been purchased by using the Debit Card.
4) The personal accident cover will be available for the beneficiaries in case of death in terrorist action/naxalite action and it will also cover death of Defense (Army/Navy/Air-Force)/Paramilitary/Police/Indian Coast Guard personnel on/off duty.
5) Insurance Company after receipt of the application will initiate the process of claim settlement. The insurance company will acknowledge the claim. All the correspondence related to claim will be directly taken up with the claimant (s) without involving Bank.
6) All the settlement/disputes will be between the claimant(s) and the insurance company and the Bank will not be a party to such disputes.
7) The claim settlement will be entirely the responsibility of the Insurance Company and Bank will have no liability towards any claim/dispute.
8) The insurance Company shall, on receipt of complete set of documents, process the claim. Any requirement/deficiencies in the documents submitted shall be sought within 15 working days of receipt of the claim. All the documents being in order, the Insurance Company will settle the claim within 30 working days from the date of receipt of last document. In case of delay beyond 30 days, the Insurance Company shall pay interest as per the IRDA regulations.
9) The claimant(s) has to submit Personal Accident Insurance Intimation Form (intimation letter) within 90 days of the accidental death of the Cardholder through speed post/registered post/courier/by hand.
10) The Personal Accident Claim Form duly filled in all respects with necessary document as per check list should be submitted within 90 days thereafter (i.e. period for intimation + claim = 90 days + 90 days = 180 days).
11) If the Debit Card holder is having more than one eligible Debit Card issued to him under one or more accounts, only one higher variant of the Debit Card will be considered for the claim purpose.
12) All claims where accident has occurred within the period of the policy and death has occurred, both (i) within the period of policy or (ii) after the expiry of policy shall be entertained by the Insurance Company. Further, as per IRDA guidelines, no claims should be rejected on account of delayed intimation and documents without ascertaining and recording the reasons for the said delay and satisfying themselves

that the claim would otherwise have been rejected even if it had been reported in time.

13) The beneficiary on death of eligible Debit Cardholder shall be as follows:
    a. Nominee, registered with the Bank for Savings Account in which the Debit Card has been issued in single name (Bank's role will be limited only to certify the name of nominee as per records of the Bank)
    b. In cases where the nominee's name is not available but the Savings Account in which the Debit Card is issued, is a joint account, then the beneficiary will be the surviving joint account holder(s) for the purpose of insurance claim. (Bank's role will be limited only to certify the names of surviving joint account holder(s) as per Bank records)
    c. In cases other than a) and b) above the claim shall be settled as per the procedure of insurer. The identification of legal heirs and the authenticity of the claim would be the responsibility of Insurer.

14) Any other supporting document/information, if required to deal with the claim would be asked for.

West Bengal Police Welfare & Sports Society
Enrollment Form

Form I

I _____(Name in full and rank) voluntarily agree to join the West Bengal Police Welfare and Sports Society after having read and fully understood the Objectives and Rules of the said Fund. I agree to pay membership fees of the Society. I further agree to accept any modifications in the rate of membership fees which Society may decide from time to time. I give my consent to the deduction from my pay the membership fees payable by me as per rules.

Signature of the applicant

Place : Name in full Father's name-
GPF Number -
Date : Rank : Post held :

Counter signature of DDO of the district/ Unit with date and seal :

Check list for Relief/Loan

A) Filled up Form-VII

Daughters/sons marriage:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Gross salary does not exceed Rs. 50,000/-
3. Age proof certificate (Bride/Groom).
4. Invitation card of marriage ceremony.

Self marriage:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Age proof certificate (Bride/Groom).
3. Invitation card of marriage ceremony.

Relief/ Medical loan:

1. Membership under WBPWASS since July 17 or date of joining (for new employee)
2. Estimated cost of treatment with supporting documents.

Check list for Scholarship

B) Filled up Form-VIII

1. Membership under WBPWASS since July 17 or date of joining (for new employee).
2. Copy of Mark sheet/Grade Card (semester wise) and admit card issued from Board/University (Attested Copy).

Check list for Scholarship (Dying in Harness)

C) Filled up Form-VIII A

1. Death Certificate of employee.
2. Scholarship to be given to wards of Ex-Police Personnel (Dying in Harness cases waiting for employment under exempted category) from schooling to college education / post graduate /diploma.
3. Documents for paying annual fees etc. for two children of deceased.

Check list for Student Education Loan

D) Filled up Form-IX

1. Membership under WBPWASS since July 17 or date of joining (for new employee).
2. Annual fees must be Rs.50,000/- and above of said course.
3. Money receipt of current course from concerned University.

FORM VII

APPLICATION FOR GRANT OF RELIEF / LOAN FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:
2. Father's Name :
3. Rank:
4. Designation :
5. Place of Posting :
6. GPF no.
7. Present Basic Pay (with Grade pay):
8. Date of birth :
9. Whether member of West Bengal Police Welfare and Sports Society :
10. Purpose for which Relief/ Loan is required:

    (i) In case of serious sickness copies of medical documents showing the following should be enclosed –

    - Total expenditure on treatment-
    - Amount received from the WBHS -
    - Amount received from Medical Insurance policy (under WBP or personal policy)-
    - Amount required as help from West Bengal Police Welfare and Sports Society-

11. Details of last financial help given to the applicant from the Society and the purpose thereof :-

    (1). Loan sanctioned with date .

    (2). Loan amount paid.

    (3). Loan amount outstanding .

12. No. of persons dependent on the applicant :
13. Details of loan already taken from other sources, viz.

    Police Co-Operative, General Provident Fund, etc.

    and monthly deductions made from pay on that account. :

14. I hereby authorize deduction of loan installments every month from my pay in … . Installments of Rs
15. In the event of my retirement, discharge or dismissal or resignation, outstanding amount of loan, if any, is also hereby authorized to be deducted from my Government dues (including pay and allowances, General Provident Fund, Gratuity etc.)

Signature of the Applicant with date

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct .
2. Certified as per service book the name of Shri/ Smt.---------- exists as dependent on Shri/ Smt.---------- (the meaning of dependent will be same as per rules of Govt. of WB)

3. General remarks (to be filled in by verifying officer):
4. Recommendations of the DSP/ SDPO/Additional SP/ SP :
5. Recommendation of Chairman of the District /Unit Committee :
6. Recommendation of the Chairman Zonal Committee :

Signature with date and seal of Head of office or officer authorized by him

* In case of dying in harness cases, the district head will send the death certificate and an application from the legal heir for writing off the loan. A separate application for financial aid needed for completion of education of dependent children or any other emergent cause may be sent to the Welfare Subcommittee through Zonal Committee.

FORM VIII

APPLICATION FOR GRANT OF SCHOLARSHIP FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:

2. Rank:

3. Designation :

4. Place of Posting :

5. GPF no.

6. Present Basic Pay (with Grade pay):

7. Whether member of West Bengal Police Welfare and Sports Society:

8. Name & age of the son/daughter for whom scholarship is prayed for :

9. (a) Name of the school/college/ Institution where admitted :

   (b) Class/M.P./H.S. or equivalent :

   Year of passing M.P./H.S./CBSE/ICSE/ISC :

   or other equivalent examination, school from

   which passed, Division and percentage of

   marks obtained (with attested copy of the

   mark-sheet and admit card)

10. 3 years degree course/ MBBS / Engineering// 5 years Law course :
    Post graduate studies / MBA/ any other course (d) Date of commencement and closing of the student's present academic session :

11. Semester wise mark sheet showing grade points :
    Issued by the College or University (attested copy)
    for students of Graduate and post graduate courses.

Date: Signature of the applicant

12. Recommendation of the District/Unit Committee :

13. Recommendation of the Chairman Zonal Committee :

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct.
2. Certified as per service book the name of Shri/ Smt.---------- exists

as dependent on Shri/ Smt.----------

- (the meaning of dependent will be same as per rules of Govt. of WB)

3. General remarks (to be filled in by verifying officer):

4. Recommendations of the DSP/ SDPO/Additional SP/ SP :

5. Recommendation of Chairman of the District Committee.

6. Recommendation of the Chairman of the Zonal Committee :

** Scholarships will be considered for students from the Academic Year 2018. (Students of class X and XII who have appeared in 2018 examination will be eligible to apply. Graduate and postgraduate students will be able to apply for scholarship as per eligibility criteria mentioned in the Rules – semester wise with effect from the Academic year beginning in summer of 2017.

FORM VIII A

APPLICATION FOR GRANT OF SPL. SCHOLARSHIP (DYING IN HARNESS) FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name of applicant:
2. Present Address:
3. Relation with deceased employee:
4. Name of deceased:

   (a) Date of death:

   (Attach attested copy of death certificate)

   (b) Rank & Designation at the time of death:

   (c) Last Place of Posting:
5. Present Gross Pension:
6. Whether employed under Exempted category:

   (Those who have already got job under exempted category & joined govt. duties are not eligible for this scholarship)
7. Name & age of the son/daughter for whom spl. scholarship is prayed for:
8. (a) Name of the school/college/ Institution where admitted:
   (Attach attested copy of admission slip issued by the institution)

   (b) Name of Class/course (Schooling to Graduation):

   (c) Period of Course:

   (d) Annual fees for the current academic session:

   (Attach Statement of course fees issued by the institution)

   (e) Fees already paid, if any:
   (Attach attested copy of Receipt of fees issued by the institution)

Date: Signature of the applicant

9. Recommendation of the District/Unit Committee:
10. Recommendation of the Chairman Zonal Committee:

FORM IX

APPLICATION FOR STUDENT EDUCATION LOAN FROM WEST BENGAL POLICE WELFARE AND SPORTS SOCIETY

1. Name:
2. Rank:
3. Designation :
4. Place of Posting :
5. GPF no.
6. Present Basic Pay (with Grade pay):
7. Date of birth :
8. Whether member of West Bengal Police Welfare and Sports Society:
9. Name of the son/ daughter :
10. Age :
11. (a) Name of the Institution/University/College where admitted :
12. Name and duration of the course :
13. Annual fees for the Course :
14. Details of last financial help given to the applicant and the purpose thereof:
15. No. of persons dependent on the applicant :
16. Details of loan already taken from other sources, viz. Police Co-Operative, General Provident Fund, etc. and monthly deductions made from pay on that account. :
17. I hereby authorize deduction of loan installments every month from my pay in .....installments of Rs.....
18. In the event of my retirement, discharge or dismissal, death, resignation, outstanding amount of loan, if any, is also hereby authorized to be deducted from my Government dues (including pay and allowances, General Provident Fund, Gratuity etc.)

Signature of the Applicant with date

CERTIFICATE

1. Certified that the information given in the above columns has been verified and found to be correct .
2. Certified as per service book the name of Shri/ Smt.---------- exists as dependent on Shri/ Smt.---------- (the meaning of dependent will be same as per rules of Govt. of WB).
3. General remarks (to be filled in by verifying officer):
4. Recommendations of the DSP/ SDPO/Additional SP/ SP :
5. Recommendation of the Chairman of the District Committee.
6. Recommendation of the Chairman of the Zonal Committee :

Signature with date and seal of Head of office or officer authorized by him

** Following shall be the eligibility conditions for application of student loan

1. Loan shall be deducted from salary in equal monthly installments.
2. DDO shall be responsible for deduction of loan from salary of the member and deposit to Society Fund.

West Bengal Health Scheme

Checklist for Reimbursement under West Bengal Health Scheme

Sl. No.	Name/Particulars of enclosures to be attached for Reimbursement Claim
1	Reimbursement Claim Form –C1/C2/C3/C4
2	Enrolment Certificate of Incumbent and beneficiary
3	Bill Summary of Indoor Treatment and OPD treatment sequentially
4	Original Bills / Money Receipts authenticated by the treating HCO
5	Copy of all prescriptions [for OPD and related OPD]
6	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate [for indoor treatment]
7	Copy of Form-H [for cashless indoor treatment]
8	Copy of Form-D4[for cashless indoor treatment]
9	Copy of all investigations/ tests report
10	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate d. Original Indemnity Bond on stamp paper [as per T.R. Form No. 14-Sec. Sub-rule(3) of T.R. 4.0841] with properly duly accepted by the unit / dist head himself. e. Enquiry report of legal heirs from local PS. f. Original application of the claimant
11	Original DDO certificate regarding admissible amount of the claim vide this office Org. No. 302(100)/Wel/Medl/20/2014 dt. 17/02/2014
12	Summary Sheet of claim vide No. 3737(2)/PL/HP/BMC/4C-119/15 dt. 20/11/15 of Pr. Secretary, Home & Hill and this office Org. No. 03/Wel/Medl-22/2016 dt. 13/01/2016
13	Original Tax / Invoice / Challan for implants, if any
14	Copy of permission [different type] required and granted, if any
15	Original prayer for condoning delay submission, if any.
16	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)
17	Duplicate set of all papers with the proposal

Note :

Form C1- for OPD treatment in empanelled HCO [with Annexure-I]

Form C2- for indoor treatment in non empanelled HCO [with Annexure-II]

Form C3- for indoor cashless treatment in empanelled HCO

Form C4- for indoor non-cashless treatment in non empanelled HCO

HCO- Health Care Organization.

All information available are in WWW.wbhealthscheme.gov.in

Manual/ Offline Reimbursement Application Form

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes ☐ No☐ Not known☐

3. Details of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details, If any		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in enlisted hospital outside West Bengal *(see clause 14 of order no.7287, dated 19.09.2008)*.	Memo No. : Date: Designation / Authority : U.O. No. and dateof Finance Deptt. West Bengal, if any:

Part-II [Details of Expenditure Statement of OPD treatment]

5. Details of OPD Treatment					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box)*[See list of diseases/illness mentioned in clause 7(1) and 7(2)]*	As per clause 7(1) of OPD List	☐	As per clause 7(2) of OPD List	☐
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. Expenditure Statement of OPD treatment		
Sl.	Name of Components	Amount

1

No.						Claimed (Rs.)
6.1	Consultation Fees					
6.2	Cost of Pathological and Radiological Investigations					
6.3	Cost of Medicines					
	Period of medicine consumption	From		To		
6.4	Cost of Special Device					
6.5	Miscellaneous (specify)					
					Total	
					No. of Vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. ;	In words; Rupees

Part-V [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Money Receipts in sequentially	Yes ☐	No ☐
4	Copy of OPD Prescription	Yes ☐	No ☐
5	Copy of permission granted if any	Yes ☐	No ☐
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
7	Copy of all investigation/ test reports in sequentially.	Yes ☐	No ☐

8	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
9	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
10	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
Name in Block Letters :
Designation/Last Designation :

Form –C2

Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID *(To be filled at the time of online entry from end the Head of Office)*	

2. Detail of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Non-Empanelled/hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if Any (Tick mark in appropriate box)	Yes☐ No☐ Not known☐

3. Detail of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

Part-II [Details and Expenditure Statement of IPD treatment]

4. Period of treatment			
Admission Date		Discharge Date	

5. Type of Discharge					
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal	☐	5.3	Referral	☐
5.2	Risk Bond	☐	5.4	Death	☐

6. Amount Claimed for		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	☐
6.2	Only Non- Procedural/ Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	☐

6.1 Details of Procedural/ Package Treatment				
Period of Procedural/ Package Treatment		From		To
Sl. No	Name of Procedures/ Packages			Amount Claimed (Rs.)
6.1.1				
6.1.2				
6.1.3				
6.1.4				

1

6.1.5		
	Total	

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment						
Period of Non-Procedural/ Package Treatment		From		To		
Sl. No.	Name of Components					Amount Claimed (Rs.)
6.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
6.3.2	Consultation Fees					
6.3.3	Pathological and Radiological Investigations					
6.3.4	Medicines					
6.3.5	Consumables					
6.3.6	Special Nursing/Aya Charges					
6.3.7	Miscellaneous. (If Any Specify)					
	Total					
	No. of Vouchers					
	Total Treatment Cost [6.1+ 6.2+6.3]					

Net Claim:*(Part-II)*	
Rs. ;	In words; Rupees

Part-III [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl.	Name/Particulars of enclosures to be attached	Enclosed or not

No.			
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent of a Non-Empanelled Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Bill Summary	Yes ☐	No ☐
4	Money Receipts in sequentially	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note and copy of death certificate	Yes ☐	No ☐
6	Detailed Bill	Yes ☐	No ☐
7	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
8	Copy of all investigation/ test reports in sequentially	Yes ☐	No ☐
9	Copy of OT Note in case of procedural/package treatment and treatment summary or bed head ticket in case of non-procedural/package treatment	Yes ☐	No ☐
10	In case of death of Employee, Pensioner and Family Pensioner; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No☐ No☐ No☐
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
12	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
Name in Block Letters :
Designation/Last Designation :

Form –C3

Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed	
2.3	Requirement of approval of delay Condonation, if any (Mark in appropriate box)	Yes☐ No☐ Not known☐

3. Details of Claimant *(applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal*(see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Cashless Mode					
Sl. No.	Particulars			Details	
5.1	Transaction ID of Cashless Treatment *(See Form-H or D4 supplied by hospital at the time of discharge)*				
5.2	Treatment Period	Admission Date		Discharge Date	
5.3	Total Treatment Cost (Rs.)				
5.4	Cashless Admissible Reimbursement Certificate (CARC)No.				
5.5	Amount paid to hospital (Rs.)				
5.6	Amount admissible for reimbursement against CARC(Rs.) *(See Row no. 16 of CARC generated through system)*				
	Total Claim of Indoor Cashless Treatment (Rs.) *(amount mentioned in 5.6)*				
	Total nos. of Vouchers/Money Receipts				

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

6. Indoor related OPD treatment		
Do you want to claim Indoor related OPD treatment		

cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes** ☐	**No**☐

7. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

8. Details of Indoor related OPD treatment Expenditure						
Sl. No.	Name of Components					Amount Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Investigations					
8.3	Cost of Medicines					
	Period of medicine consumption	From		To		
8.4	Cost of Special Devices					
8.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of Vouchers					

Part-IV [Medical Advance]

9. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

10. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus Part-V]*	
Rs. ;	In words; Rupees

Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrollment Certificate of beneficiary	Yes ☐	No ☐
2	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes ☐	No ☐
3	Money Receipts of both Indoor and OPD treatment sequentially	Yes ☐	No ☐
4	Copy of related OPD Prescriptions sequentially (if claimed)	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes☐	No ☐
6	Copy of Form-H	Yes ☐	No☐
7	Copy of Form-D4	Yes ☐	No☐
8	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes ☐	No☐
9	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
10	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
11	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant :
Name in Block Letters :
Designation/Last Designation :

Form –C4

Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

under **West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed	
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes ☐ No ☐ Not known ☐

3. Details of Claimant *(applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal[*see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:
4.2	For treatment availed in enlisted hospital outside West Bengal *(see clause 14 of Order No.7287, dated 19.09.2008*).	Memo No. : Date: Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Reimbursement Mode(If No is selected in Sl. No 3)				
Period of treatment	Admission Date		Discharge date	

6. Type of Discharge					
Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal	☐	6.3	Referral	☐
6.2	Risk Bond	☐	6.4	Death	☐

7.Amount Claimed for		
Sl. No.	Type of Treatment	(Tick mark in appropriate box)
6.1	Only Procedural/ Package Treatment	☐

1

6.2	Only Non- Procedural/ Non-Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	☐

7.1 Details of Procedural/ Package Treatment

Period of Procedural/ Package Treatment	From		To	

Sl.No.	Name of Procedures/ Packages	Procedure Code	Amount Claimed(Rs.)
7.1.1			
7.1.2			
7.1.3			
7.1.4			
7.1.5			
		Total	

7.2 Details of Implants Used

Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.

Period of Non-Procedural/ Non-Package Treatment.	From		To	

Sl. No.	Name of Component					Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Investigations.					
7.3.4	Medicines.					
7.3.5	Consumables					
7.3.6	Special Nursing/Aya Charges					
7.3.7	Miscellaneous. (If any specify)					
	Total Claim of Reimbursement Mode of Treatment(Rs.) (amount mentioned in 7.1+ 7.2+7.3)					
	No. of vouchers					

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

8. Indoor related OPD treatment

Do you want to claim Indoor related OPD treatment cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes** ☐	**No**☐

9. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

10. Details of Indoor related OPD treatment Expenditure						
Sl. No.	Name of Components					Amount Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Investigations					
10.3	Cost of Medicines					
	Period of medicine consumption	From		To		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of vouchers					

Part-IV [Medical Advance]

12. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

13. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus V]*	
Rs. ;	In words; Rupees

Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrollment Certificate of beneficiary	Yes ☐	No ☐
2	Bill Summary of Indoor Treatment and OPD treatment	Yes ☐	No ☐
3	Money Receipts of both Indoor and OPD treatment in sequence manner (In chronological order)	Yes ☐	No ☐
4	Copy of related OPD Prescriptions (if claimed)	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes☐	No ☐
5	Copy of permission granted if any	Yes ☐	No☐
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011	Yes ☐	No☐
8	Copy of Detailed Bill of Indoor Treatment	Yes ☐	No ☐
9	Original copy of Voucher/ Tax Invoice/Challan of Implants	Yes ☐	No ☐
10	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment sequentially	Yes ☐	No ☐
11	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes☐	 No☐ No ☐ No ☐
12	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes☐	No ☐
13	Any other instruments (Specify)	Yes ☐	No☐

Date:

Signature of the Employee/Pensioner/Claimant :
Name in Block Letters :
Designation/Last Designation :

Annexure-I

Certification of Treating Specialist of **Empanelled Hospital** for claiming reimbursement of **"Out Patient Department"** treatment under WBHS

1. Certified that the patient, Sri/Smt._____ is a beneficiary of West Bengal Health Scheme having the Beneficiary ID is_____.

2. S/he has been suffering from_____(specify name of disease) as listed in Sl. No._____ of the OPD list as per 7(1) clause or follow-up medical attendance and treatment of _____ as per 7(2) clause of order number 7287-F, dated 19/09/2008 issued by Medical Cell, Finance Department, Government of West Bengal.

Date:

Signature of the Treating Specialist
Registration No: .....
Registering Authority:.....
Present Degree: .....
..... Hospital

Official Seal of Treating Hospital

List of OPD (Out-Patient Department) Diseases

As per clause 7(1) of 7287–F, dated; 19-09-2008				As per clause 7(2) of 7287–F, dated; 19-09-2008	
Sl. No	**Name of Disease**	**Sl. No**	**Name of Disease**	**Sl. No**	**Name of Disease**
1	Malignant Diseases.	10	Injuries Caused by Accident (including Animal Bite).	1	Neuro Surgery.
2	Tuberculosis.	11	Rheumatoid Arthritis.	2	Cardiac Surgery (Including Coronary Angioplasty and implants).
3	Hepatitis B/C and Other Liver Diseases.	12	Systematic Lupus Erytthematous (LUPUS).	3	Cancer Surgery/ Chemotherapy/ Radiotherapy.
4	Insulin Dependent Diabetes (Type-2 Diabetic Mellitus is not considered as Insulin Dependent Diabetes).	13	Crohn's Disease.	4	Renal Transplant.
5	Heart Diseases.	14	Endodontic Treatment (Root Canal Treatment).	5	Hip/ Knee replacement Surgery.
6	Neurological Disorder/ Cerebra vascular Disorders.	15	COPD (Chronic Obstructive Pulmonary Disease).	6	Accident cases.
7	Malignant Malaria.	16	Ankylosing Spondylitis		
8	Renal Failure.	17	None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]		
9	Thallasaemia/ Bleeding orders/ Platelet Disorders.				

Annexure-II

Certification of Medical Superintendent/ Administrative Officer and Treating Specialist of treating in **Non-Empanelled Hospital** for claiming reimbursement of only **"Indoor"** treatment under WBHS

1. Certified that the patient, Sri/Smt._____ is a beneficiary of West Bengal Health Scheme having the Beneficiary ID is_____ availed indoor treatment from _____ to _____.
2. Certified that the Hospital/Nursing Home/Health Care Organisation has _____ ( ) nos. of bed.
3. Certified that the Hospital/Nursing Home/Health Care Organisation obtained a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____ and this License is valid up to _____.

Date:

Signature of Medical Superintendent
..... Hospital
Official Seal of the Hospital