

SAMYUKTA GOWDA SARASWATA SABHA

55, Habibullah Road, T.Nagar, Chennai 600 017

APPLICATION FOR MEDICAL TREATMENT

1. Name of Applicant:		M/F		
		Age(DOB)		
2. Address:				
Contact Telephone No.				
3. Occupation of the Applicant/Guardian If employed, name of the Employer and contact No.				
4. Total Annual Family Income (Proof needed) Rs. (including income from other sources such as interest, dividends, rentals etc.)				
5. Details of Assets:				
6. Name of family members				
Name	Date of Birth	Relationship	Is the person earning	If so, annual income Rs.
7. Name of person for whom assistance is needed:		M/F		
		Age (DOB)		
8. Relationship				
9. Nature of illness/disability:				
10. Treatment taken (Doctor's certificate to be furnished)				
11. Are you entitled for any assistance from your employer directly or through insurance: If yes, the amount of assistance: Rs.				
12. Reason for not able to pay the balance:				
13. Do you have personal medical insurance?				
14. Place where treatment was taken:				
15. Expense incurred on: (with Doctor's counter signature)		Rs.		
Surgery				
Medicines				
Lab/clinical tests				
Nursing				
Others (Specify)				
16. Any other information you would like to share:				
I solemnly affirm that all the particulars and information furnished by me in this application are true. If at any time this is found to be wrong, I am bound to refund the assistance.				
Date:		Signature		

RECOMMENDATION BY TWO MEMBERS
(After verification based on the scheme guidelines)

We have verified the applicant's case and have satisfied ourselves with the genuineness and of the information recorded therein. We recommend the case for Sabha's assistance.

1. Signature

2. Signature

1. Name of the recommender:

2. Name of the recommender:

Address:

Address:

Phone:

Phone:

Date:

Date:

RECOMMENDATIONS OF THE SCREENING COMMITTEE

The person was seen by us on -----

Recommendations:

We recommend/do not recommend the request for assistance
or
We need to have additional information regarding

Signatures:

Dr. H.R. Shanbhogue

Dr. Mrs. Sudha Pai

Dr. Mrs. Shantha Kamath

Action by the Sabha:

**Approved
Sanctioned Rs.-----**

Hon. Secretary

Date:

Paid by Cheque No.

Dated:

For Rs.

Manager

INSTRUCTIONS:

(Read the instructions carefully before filling the application form)

1. Eligibility:

(a) Total family income not exceeding Rs.3,00,000 per annum.

A proof of gross annual family income should be attached to the application form.

2. Total Annual Income means the total of all income of all the members in the family including income from all sources such as interest, dividends, rentals, etc. and before any deduction such as Provident Fund, Insurance Premium, repayment of Loans, Taxes payable etc.

3. Details of assets, if any, and value should be furnished.

4. **Treatment taken:** A certificate from the Doctor/Hospital/Institution where the treatment was taken and indicating the cost of treatment.

5. The Sabha reserves the right to reject any application or to stop/withdraw the assistance without assigning any reason.

6. The Scheme is limited to SGS Sabha Members and their dependents who are residing within the City limits of Chennai