

**THE CANARA BANK OFFICERS' ASSOCIATION****HOSPITALISATION SCHEME CLAIM FORM**

FROM:	DATE:
NAME	SUBMITTED THROUGH:
STAFF ID	THE REGIONAL SECRETARY,
DESIGNATION	CANARA BANK OFFICERS' ASSOCIATION
BRANCH	REGION:

SUB: MEDICAL REIMBURSEMENT UNDER WELFARE SCHEME EVOLVED BY ASSOCIATION.

I am submitting my claim for the reimbursement of Hospitalization Expenses incurred for Self/Spouse, under the scheme evolved by the Association as per circular No. GSCO/05/2005 dt 25.07.2005. Full particulars are as under:

NAME OF THE MEMBER	
BRANCH/OFFICE/REGION PRESENTLY WORKING	
NAME OF PATIENT AND RELATION	
NATURE OF AILMENT	
DATE/S OF HOSPITALIZATION	
DATE OF OPERATION/SURGERY	
AMOUNT ACTUALLY INCURRED BY MEMBER	
AMOUNT SANCTIONED BY BANK	
SANCTION PROCEEDING NO AND DATE	
AMOUNT DISALLOWED BY THE BANK	
MOBILE NUMBER	
ACCOUNT NUMBER	
BRANCH/OFFICE/REGION PRESENTLY WORKING	

Thanking You,	AMOUNT SPENT	MAX FOR SELF	MAX FOR DEPENDENT
	35000-50000	20000	10000
Yours faithfully,	50001-100000	30000	15000
	100001-200000	60000	30000
	200001-300000	100000	50000
(signature)	300001-400000	150000	75000
	400001-500000	200000	100000

Forward to The Secretary, CBOA Welfare Fund, Mumbai.:

On verification of the records available with us, original copies submitted by member, I certify that the claim is genuine. Also per records available there are no arrears from this member

(REGIONAL SECRETARY)	REMARKS :
NAME	1. PARENT NOT ELIGIBLE
CONTACT	2. COMPLETELY DISALLOWED CLAIM NOT ELIGIBLE
A/C NO	3. SEND SEPARATE FORM FOR EACH CLAIM
	4. SANCTION XEROX COPY MUST BE ENCLOSED