

Annexure 1
(Refers to Para 5 of Appendix E)

APPLICATION FOR FINANCIAL ASSISTANCE FROM KSB: MEDICAL TREATMENT
(Only for Non Pensioners upto Havildar/Equivalent)

1. Name: _____ Service No: _____ Aadhar No: _____
2. Rank _____ 3. Present Address: _____
- _____
4. Dates: (dd/mm/yy) Enrolment: ___/___/___ Discharge: ___/___/___ Birth: ___/___/___ Death: ___/___/___
5. Reasons for discharge: (As in Discharge Certificate): _____
6. Character at the time of discharge: Exemplary / Very Good / Good / Fair / Bad.
7. Dependents of ESM Son/Daughter
- a) Wife: _____ e) _____
- b) Mother: _____ f) _____
- c) Father: _____ g) _____
8. Mobile No: _____ Residence Landline No: _____
9. (a) If re-employed, income there from employment : Rs. _____
- (b) Monthly income for non-pensioners (from other sources) Rs. _____
10. Details of Financial Assistance received in past from KSB/RSB/ZSB(mention each type of grant):
- Name of grant _____ Amount _____, year : _____
11. Name and address of Bank: _____
12. IFSC/ NEFT Code of Bank: _____ 13. Account No. _____
14. Additional Information if any _____

DECLARATION

15. I understand that this is a financial assistance meant for medical treatment **upto Rs 30,000/-** only and not a reimbursement scheme. I have no legal right on the amount requested for or spent by me on medical treatment.
16. I solemnly declare that I have not received any financial assistance or grant or re-imburement of medical expenses from Govt, current employer or any other agency.
17. I hereby declare that the information furnished in personal application cum financial condition report is correct to the best of my knowledge.

(Signature of the applicant)

RECOMMENDATIONS BY ZSW OFFICER

18. Following original documents of ESM/Widow have been personally checked by ZSW Officer (Photocopies attested by ZSWO are attached): -
- (a) Complete Discharge Certificate/book showing details of ESM widow and children
- (b) Original medical bills/receipts duly countersigned by the attending doctor.
- (c) Discharge certificate/summary from the hospital and countersigned by the attending doctor.
- (d) ESM/Widow I-Card.
19. It is certified that the applicant has not been provided any financial assistance from the State Govt or any other source. It is also certified that the applicant is not an ECHS member.
20. I hereby confirm that the information furnished above is correct as per the original documents of the applicant. Hence, case is **recommended**.

Date :

Office Seal :

Signature :

Rank & Name:

Designation : Dy Dir/Asst Dir/ZSWO