STATE BANK OF INDIA

RETIRED EMPLOYEES' MEDICAL BENEFIT TRUST

CLAIM FOR REIMBURSEMENT OF DOMICILIARY TREATMENT

01	Name of the employee (member pensioner)	
02	Date of Retirement Membership Number	
03	Whether claimed for self/spouse	
04	Address & Telephone No.	
05	Retired As	
06	Pension Paying Branch SB A/C No.	
07	Nature of illness	
08	Name of the dependent family member for whom the Medical Expenses made Name - Age - Relationship -	
08	Duration of illness	
09	Name & address of the attending Physician	
10	Details of expenditure incurred & claim to be submitted alongwith Doctor's prescription--as per reverse	Total Amount
11	I certify that I have incurred above expenses for myself & / eligible family members	

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Signature of the pensioner member

Forwarded for payment

Branch Manager

Branch _____

DETAILS OF THE BILLS

BILLNO.	DATE	PARTICULARS OF THE BILL	AMOUNT	
TOTAL				

Signature of the pensioner member

AT ADMINISTRATIVE OFFICE

Amount of the expenditure claimed for Domiciliary treatment Rs.

Amount of expenditure for Domiciliary treatment already claimed during the year Rs.

Balance available for domiciliary treatment Rs.

sanctioned Rs. Towards Domiciliary treatment

Chief Manager (HR) Assistant General Manager (ADMIN)