APPENDIX-I

KERALA STATE ELECTRICITY BOARD LIMITED

APPLICATION FORM FOR INTEREST FREE MEDICAL ADVANCE

1) Name of the applicant :
2) Designation :
3) Name of Office :
4) Name of ARU :
5) Date of Birth :
6) Date of entry in service :
7) Date of Superannuation/Retirement :
8) Pay and Scale of Pay :
9) Nature of appointment (Provisional/Regular) :
10) Length of service as on the date of application :
11) Length of remaining service as on the date of application :
12) Whether the applicant is an Officer or Workmen : Officer/Workmen
13) The designation of the Drawing Officer/ Countersigning Authority :
14) The Name of the ARU from which the amount is proposed to be drawn :
15) Name & address of the patient with relationship with the applicant :
    (i) Name of Hospital
    (ii) Age of the Patient
16)
    (a) Whether the patient is working elsewhere (applicable if the patient is other than Board Employee). : Yes/No
    (b) If yes, details of employment of patient

Name & Designation of the Patient	Name of the Organization/ Department	Reason for not availing Medical Advance from his/her employer	Whether Joint Declaration Submitted (Furnish a copy)

17)
    (a) Whether the patient is a Service Pensioner/Family Pensioner : Pensioner/Family Pensioner
    (b) If yes, furnish the details
18)
    (a) Whether the patient is coverage of any Medical Insurance Scheme : Yes/No
    (b) If yes, furnish the details
19) Purpose for which Medical Advance is required :
    (i) Name of Hospital
    (ii) Period of treatment
    (iii) Date of Surgery/Treatment
    (iv) Name of Surgery/treatment

20) Amount to be deposited :
21) Approximate expenditure for the treatment as in-patient :
22) Amount of advance required :

23) Whether the Medical Advance was availed previously: Yes/No
(if yes furnish the details

Sl. No.	B.O.No.& Date	Amount of Advance	Date of Drawal of advance	Amount utilized for treatment	Unutilized portion of advance remitted or not if so details)	Balance amount if any outstanding after adjustment of Medical Advance	Details settleme of advan with Ord No.

24) In dependent parents' case, whether the patient has any other children other than applicant
(a) If yes, No. of children and their income profile may be furnished (age, profession, annual income of each) : Yes/No

Sl. No.	Name	Age	Profession	Annual Income	Nature of Employn (Private/Governme Abroad

25) The DDOs/HODs may countersign the estimate from the Hospital authorities :

Certified that the information given above is complete and true and that I will comply with the rules laid down in the case of Interest Free Medical Advance from time to time

Signature of applicant :
Name :
Designation :

ENQUIRY CERTIFICATE

1. Certified that the applicant has no other means to raise the amount for meeting the expenditure.
2. Certified that I have made enquiries about the purpose for which the Advance is applied for and have been satisfied myself with the genuineness of the facts attached to with this application.
3. Certified that the applicant will continue in service till the complete repayment of the Advance as per existing Rules/Orders.

Place:....................
Date :................

Signature :
Name & Signature of ARU Head:

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