D 4	C	• ,	C	1.	, •
Date	ot re	ceint	ot a	nnlic	ation:
Duit		CCIPU	OI U		ation.

ANNEXURE III

Signature of the Officer receiving the application:

## FORM - B ( FOR NON MEMBER APPLICANT )

# THE STATE BANK OF INDIA RETIRED EMPLOYEES MEDICAL BENEFIT SCHEME - III

(Membership-cum-Declaration Form to be used by the fresh applicants of the State Bank of India Retired Employees Medical Benefit Scheme -III)

(FOR THE USE OF REGULAR RETIREES, OTHERTHAN VRS/ EXIT / VOLUNTARY RETIREMENTS ETC.)

Membership No. of the Scheme - III								
(To be filled at the Admin Office)								
(A joint photograph of the member and spouse should be affixed in the box. =>								
(The Branch Manager/ Head of the Depart receiving the application should attest photograph. A copy of the photograph du by the Branch Manager/ Head of the Depa receiving the application should also be enclosed with the form)	the ply signed artment							
1. Name of the employee	:							
2. Address with Pin Code & Contact Number	:							
Residence Number Mobile Number								
3. Provident Fund Index Number	:	]						
4. Date of Birth	:							
5. Date of joining the service								
6. Date of confirmation in the service								
7. Date of retirement								
8. Retired as	:							
9. Age (in Years) as on the date of retirement	:							
10.Whether Rule 19(3) was invoked on attaining the age of retirement. If yes, please furnish the details of the disciplinary case, date of it conclusion and penalty, if any impos	cs							
11.Name of the Branch/Office from where retired	<b>:</b> :							

12. Whether retired on attaining the age of retirement/superannuation or on medical grounds on being declared permanently incapacitated by bodily or mental infirmity from further active service (such infirmity not being the result of irregular or intemperate habits) by a Medical Board constituted for the purpose and pension sanctioned under rule 19(ii)/22(iii) of IBI\SBI Employees' Pension Fund Rules. If retired on medical grounds, copy of the report of Medical Board constituted for the purpose be enclosed.  13. Code Number & name of the Branch from where pension is being drawn  14.Details of pension (copy of Pension payment advise should be enclosed)							F A D	DR FAR FADI earr	ness		] ] i <b>ef</b> ]					
45 -		6	a 1				Т	'OTAI				Rs.				
15.Proposed (Please tic						•										
PLAN PLAN	PLAN	PLAN		PLAN	PLAN	Ē	LAN	I	PLAN				Γ	PLA	/N	1
A B	С	D		A-1	B-1		C-1		D-1				L	E		
16.Contribu	ıtion p	ayable	for the	Plan i	n Rs.	:										
medical	of the benef	e curre	ent empl ailable	oyer and	d	:				Rs						
18. (a) Nam	ne of t	the spou	ıse		:  -	+							+			
(b) Dat	e of b	oirth o	f the sp	ouse	: _											
19. If the spouse is currently employed, please state the details of her/his current employer and medical benefits available there from																
20.Details pension for	life	valid ch		ldren, :	if any	wh	o ha	s/ha	ve be	een	sanc	tio	ned			
	- •	Age		Da	ate of	Bir	th :									
21.Savings	Bank a	account	no. at	pension	paying	j br	anch	:								
22.Details	of Dra	aft enc	losed.													
Draft No. Amount Date of dra Issuing bra Drawn on	-															
Date Place							(SI	GNAT	URE (	OF T	не м	EMB	ER)			

#### **DECLARATION**

We declare that-

- (i) The particulars given above are correct.
- (ii) We have read and understood the terms and conditions of the Scheme III and undertake to abide by the same.
- (iii) We shall not make any false claim from the Bank under the Scheme. In the event of our making any false medical claim or not settling the medical bill, we are liable to forfeit the benefits under the Scheme(s) as also our membership to the Scheme.
- (iv) We undertake to pay to the hospital all expenses in excess of our eligibility for treatment under the Scheme and the Bank will not be liable for any such expenses in excess of our eligibility. The Bank is also hereby authorized to recover our share of the medical bill from our Pension Family Pension or from the legal heirs in case this is not paid by us within 15 days of receipt of advice thereof. A copy of this authorization is being registered with the Trustees of the Pension Fund.
- (v) We also note that in case the Bank decides to wind up the Scheme and dispose off the contributions/fees received from them in a manner deemed fit we shall have no legal claim against the Bank or the Managing Committee or the Trust.

(SIGNATURE OF THE SPOUSE)

Name:

Date:

(SIGNATURE OF THE MEMBER)

Name:

Date:

Branch
Code Number:
Date

(Counter signature by the Branch Manager of the branch from where pension Is being drawn)

### FOR USE AT ZONAL OFFICE

L.	Eligibility's	for	medical	benefits:	Rs.	/under	Scheme	III

- 2. Amount of Benefit availed so far by the Member: Rs.
- 3. Balance amount left to the credit of member under Scheme II (1-2): Rs.
- 4. Plan opted for: A-1/B-1/C-1/D-1/E
- 5. Maximum eligibility under the Plan: Rs 3/4/5/7/10/15/20 lac
- 6. Amount of eligibility of Member (Rs 3/4/5/7/10/15/20lac Amount in 3): Rs.

To be carried forward to the ledger sheet and pass book: Rs

Date: Place:	
	(SIGNATURE WITH DATE OF
	THE OFFICER INCHARGE OF THE
	SCHEME AT Admin. OFFICE)
	0

## ACKNOWLEDGEMENT

(to be given to the applicant by the branch/office receiving the Form)

Received from Shri/Smt.			
Membership-cum-Declaration			Employees
Medical Benefit Scheme -III	along with the	draft No.	dated
for Rs,,,,onward submission to Zonal		and drawn on	for
Date Branch	Stamp of the Bra	nch Signature o officer receivir	