APPLICATION FORM FOR REQUESTING REIMBUSEMENT OF MEDICAL EXPENSES FROM THE COMPANY SECRETARIES BENEVOLENT FUND (CSBF)
(in deserving* cases only)

The Secretary & Treasurer
Company Secretaries Benevolent Fund
ICSI House, 22, Institutional Area, Lodi Road,
New Delhi-110003

Dear Sir,

I am a member of The Institute of Company Secretaries of India (ICSI). I have incurred certain expenses towards medical treatment of myself/my dependents**. I request for financial assistance from CSBF by reimbursing the medical bills enclosed herewith for the treatment availed.

I submit the following particulars for your reference and consideration:

1	Name of the ICSI Member (in Capital Letters)	Mr./Mrs./Ms._____
2	ICSI Membership Number	ACS / FCS - _____
3	CSBF Life Membership Number	LM-_____ Tick here ( ) if Non-member of CSBF
4	Present Full Address (in Capital Letters)	_____ _____ CITY_____DISTRICT_____ STATE_____ PIN CODE_____
5	Landline Number/Mobile Number	
6	Email ID	
7	Annual Income in last Financial Year [attach self-attested copy of Income Tax Return (ITR) filed for the last financial year]	Rs._____
8	Name of Patient who underwent medical treatment *(Patient should be self or a declared dependent of the CSBF Member)*	
9	Relationship of Patient with Member *(for non-members of CSBF, request for medical reimbursement is limited to self only)*	
10	Nature of Disease	
11	Amount of Financial Assistance sought from CSBF towards medical reimbursement (supported by medical report(s), original bills and payment receipts)	Rs._____

12	Total Amount of Financial Assistance availed earlier from CSBF towards medical reimbursement of self/declared dependents	Rs._____on_____(date) Rs._____on_____(date) Tick here ( ) if Not Applicable
13	**NEFT Details:**	
	Name and Address of the Bank	
	Name of the Account Holder/Member	
	Account Number	
	IFSC Code	

* Having annual income less than Rs.7,50,000/- in the last financial year
**Dependent includes wife / husband, dependent children (including step children) and wholly dependent parents.

'Dependent children' is defined as under:
(a) Son - till he starts earning or attains the age of 25 years or gets married, whichever is earlier;
(b) Daughter - till she starts earning or attains the age of 25 years or gets married, whichever is earlier; and
(c) Disabled Son or Daughter suffering from permanent disability of any kind physical or mental) - No age limit

I enclose herewith the following documents in support of request for reimbursement of medical expenses incurred:
1. Copy of doctor prescription and diagnosis/medical reports
2. Original bills and Original Payment Receipts of the Hospital/Nursing Home (***Medical bills/payment receipts submitted not beyond the period of six months (180 days) from the date of such bill/receipt, the submission date being the date of which such bills/receipts are received at the Institute shall only be considered eligible for reimbursement from CSBF***)
3. Report of Medical Examination
4. Self-attested copy of my Income Tax Return (ITR) filed for the last Financial Year
5. Copy of my cancelled cheque with name printed/bank passbook.

I declare that I have neither applied for nor received reimbursement from any other source for the expenses incurred as mentioned hereinabove and that I had an annual income of less than Rs.7,50,000/- in last financial year. I declare that I had not availed any medical reimbursement from CSBF in the past or if availed then I have given details hereinabove. I declare that the information provided above is true to best of my knowledge and information. I owe full responsibility to return the amount reimbursed if information provided above are found false to the fact at any point of time.

Yours faithfully,

Signature:

Place: _____

Name_____

Date: _____

Membership No. ACS/FCS_____