

PART – III

FORMS

Defence Civilians Medical Aid Fund (DCMAF)
(Application Form for Joining the Fund)

I hereby apply for membership of the Fund. My particulars are as under:-

1. Name of the Applicant :
2. Date of Birth :
3. Date of Retirement :
4. Personal/Employment No. :
5. Token/I Card No. :
6. Rank/Designation/Post Held :
7. Complete Address of the Office Where Employed :
8. Present Pay Band :
9. Present Grade Pay :
10. **Details of Payment of Membership Fee:**
 - (a) By Cash :Rs.-----/-
 - (b) By Bank Draft No. _____ Dated _____

(Drawn on _____ for Rs. _____ in favour of **“Defence Civilians Medical Aid Fund” payable at New Delhi.**

 (Please forward a consolidated single Bank Draft in case subscription is realized from two or more members)

Station _____

Signature of the Applicant

Date _____

NOTE : This application form shall be maintained by the office in which the member of the Fund is serving. In case of transfer this authority should also be sent to the Head(s) of the concerned Establishment (s) to effect further recovery of subscription from the members (other than the donors i.e. full service members).

For further details kindly see rules or contact at Porta Cabin Room No.1, B-Block, Nirman Bhawan Post Office, Dalhousie Road, New Delhi-110011, Tele-011-23011185

Defence Civilians Medical Aid Fund

LEDGER OF ANNUAL MEMBERSHIP

Membership Number _____

Member's Name _____

Name of the Estt _____

Designation/Employment No/P.No. _____

Date of Birth _____

Date of Joining DCMAF _____

Date of Retirement _____

**SUBSCRIPTION RECOVERED FOR THE LAST TEN YEARS
IN CASE OF ACCIDENTAL EX-GRATIA**

Year	Amount	Paid on	Signature of Collecting Authority with date

REGISTER OF FULL SERVICE
MEMBERSHIP

<u>SL.</u> <u>NO</u>	<u>NAME OF</u> <u>MEMBER</u>	<u>DESIG</u>	<u>EMPLOYEMNT</u> <u>NO/PERSONAL</u> <u>NO.</u>	<u>AMOUNT OF</u> <u>SUBS PAID</u>	<u>DATE OF</u> <u>SUBS PAID</u>	<u>MEMBERSHIP</u> <u>NO.</u>	<u>DOB</u>	<u>DOR</u>	<u>REMARKS</u>
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									

-
- i DESIG - DESIGNATION
 - ii SUBS - SUBSCRIPTION
 - iii DOB - DATE OF BIRTH
 - iv DOR - DATE OF RETIREMENT

APPLICATION FORM FOR GRANT OF MONERARY ASSISTANCE FROM THE DEFENCE CIVILIANS MEDICAL AID FUND

1. **Particulars of the member (applicant):**

- a) Name :
- b) Membership Card No. :
- c) Designation/P.No :
- d) Unit in which employed :
- e) Date of Joining the Defence Civilians Medical Aid Fund :.....
(the date on which the first subscription was paid)
- f) Has he/she ever availed of the assistance from the Fund in the past? If so, give Letter No. of DCMAF :.....

2. **Particulars of the patient :-**

- a) Name.....
- b) Date of Birth of the Patient.....
- c) Relationship with the applicant.....
- d) Disease from which he/she is suffering.....
(state TB, Cancer or Leprosy).....
- e) Date of onset of the disease.....
- f) Does the income of the patient exceeds Rs. 1500/- p.m.
(in case of dependent patients only).....
- g) Whether solely dependent upon the applicant and residing with him/her.....
- h) Institution/hospital where the patient was/is receiving treatment (state period).....

Contd...

- i) Has he/she been declared medically fit to resume normal duties or is still on leave?
- (i) If former indicate date on which he/she resumed duty.....

&

Whether treatment has been completed or the patient is still taking active treatment

- (ii) If letter, indicate the period for which the leave has been granted.....

Station.....

Date.....

Signature of applicant
(Member)

II

Recommended. The information furnished at items 1 and 2 above has been verified service documents and are confirmed.

Signature of the Head of the Office
(With seal)

MEDICAL REPORT APPENDED TO THE APPLICATION ASKING FOR ASSISTANCE FROM THE DEFENCE CIVILIANS MEDICAL AID FUND FOR TUBERCULOSIS

1. Particulars of the patient:

- a) Name (in block letters) :
- b) Relation with member :
- c) Date of birth of the Patient :
- d) Signature or Thumb impression of the Patient and date (to be affixed in the presence of attending physician) :
- e) Disease suffering from (State type of TB):
- f) Site of lesion :
- g) Date of onset of the disease :
- h) Whether a fresh or relapse case :
- i) Date treatment started :

**2. Present clinical and other findings with date :
(put date here)**

- a) Sputum :
- b) E.S.R. (with method) :
- c) Hb% :
- d) Biopsy findings (in case of TB Lymphadenitis, cold abscess tuberculosis and skin TB)(attach copy of report) :
- e) Fever :
- f) Cough :
- g) Haemoptysis :
- h) Dyspnoea :

3. Radiologist's Report on X-ray film
(Date of film to be given) :
(see notes) (Signature)

4. Medicines prescribed (see Note.3) with dosage:

- a) Total duration of treatment
- b) Already taken as on date
- c) 3m/6m/12m/18m/24m/30m/36m.

Contd...

5. Certified that the patient, whose particulars are given above, is suffering from..... and requires active treatment for approximately a further period of months to complete the treatment. He/She/is fit/unfit/ to attend normal duties/work/and is/ is not/infectious to others.

6. Opinion of Medical Specialists/Chest/T.B. Specialist with name, designation & date (See Note.4).

Station :.....

Date :.....

Signature and seal of the Authorized
Medical Attendant/MO i/c/case/ Specialist/
MS of Armed Forces/MO of an Ord.
Fy. Hospital

NOTE: -

1. The medical reports should be completed and authenticated in all respects by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medical Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital
2. Medical report should be supported by a latest X-ray film (not more than six months old) of the patient alongwith the Radiologist's Report. The previous X-ray film should be placed for comparison.
3. The total duration for which drugs have been taken should be mentioned. Any change of regimen and the reason for the same (Resistance, etc) should be mentioned.
4. The opinion of specialist (please see Note (i) above) has to be obtained and enclosed here in all those cases where treatment has been prolonged for over one year and/or the drug regimen has been changed due to development of drug resistance/complications and following relapse.
5. Radiologist's Report, if not available at source/the same may be had from a private Radiologist and the charges thereof claimed from the Fund by furnishing the Radiologist's Cash Memo.
6. **Documents required:**
 - i) The first application shall be made in the proforma given in Form-4.
 - ii) Blood and Sputum report from Laboratory.
 - iii) X-ray film duly supported by Radiologist's Report.
 - iv) Previous X-ray film in case of review cases.

**MEDICAL REPORT APPENDED TO THE APPLICATION
ASKING FOR ASSISTANCE FROM THE
DEFENCE CIVILIANS MEDICAL AID FUND
FOR LEPROSY**

1. Particulars of the patient:

- a) Name (in block letters) :
- b) Relationship with member :
- c) Date of birth of the Patient :
- d) Signature or Thumb impression of the Patient and date (to be affixed in the presence of attending physician) :
- e) Disease suffering from (State type of Leprosy) :
- f) Site of lesion :
- g) Date of onset of the disease :
- h) Date of treatment first initiated in the case:.....

**2. Present clinical and other findings with date :
(put date here)**

- a) Site of lesions :
- b) Nature of lesions :
(Depigmentation, anesthesia, neural, thickening, infiltration)
- c) Fever :
- d) E.S.R. (Wintrobe/Westergren) :
- e) Hb% :
- f) Bacterial Index.(B1) (See Note-4): i) Present B1.....
ii) Last B1.....
Taken on.....(date) Taken on.....(date)
- g) Biopsy findings (with date) :
(attach a copy of report)

**3. Treatment/Medicines prescribed and duration of treatment already completed as on date:
(Please give full details dosages, changes in drug regimen, if any):**

- a.Total duration of treatment
- b.already taken as on date
- c.3m/6m/12m/18m/24m.

Contd...

4. Certified that the patient, whose particulars are given above, is suffering from..... and requires active treatment for a further period of approximately.month(s) to complete the treatment. He/she is fit/unfit to attend normal duties/work and is/is not infectious to others.

Station.....

Dated.....

Signature and seal of the Attendant/MO
i/c case/Specialist/MS of Armed Forces/
MO of an Ord. Fy. Hospital

NOTE:-

1. This medical report should be completed in all respects. The report should be completed by Specialist in Dermatology. In case the services of the Specialists are not available, the report should be completed by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medial Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital
2. Complicated Cases. In case the treatment has been prolonged for over 1 year and/ or, in case of change of drug regimen due to drug resistance/reaction, detailed notes may be given by a Specialist Medical Officer.
3. Histopathological report (Biopsy report) issued by the Lab. will be placed alongwith this Medical Report.
4. Bacterial Index (B1). This is the only objective method of monitoring progress. Bacterial Index is calculated based on the number of bacteria and in each microscopic field of smears taken from a minimum of 7 sited which include both ear lobules, nasal mucosa and 4 skin lesions. For details of calculations please refer to chapter on Leprosy in Text Book. For monitoring progress please give B1 calculated during present examination and the last examination.
5. **Documents required:**
 - i) The first application shall be made in the proforma given in Form-4.
 - ii) Biopsy report.

**MEDICAL REPORT APPENDED TO THE APPLICATION
ASKING FOR ASSISTANCE FROM
THE DEFENCE CIVILIANS MEDICAL AID FUND
FOR CANCER**

1. Particulars of the patient:

- a) Name (in block letters) :
- b) Relationship with member :
- c) Date of birth of the Patient :
- d) Signature or Thumb impression of the Patient and date (to be affixed in the presence of attending physician) :
- e) Disease suffering from :
- f) Site of lesion :
- g) Date of onset of the disease :
- h) Date of treatment first initiated in the case:.....

2. Present clinical and other findings with date :
(put date here)

- a) Clinical findings :
- b) E.S.R. (Winrobe/Westergren method) :
- c) Hb% :
- d) Histopathological finding (Biopsy FNAC)
(attach copy of report) :
- e) Any other investigations :

3. Treatment/Medicines prescribed and duration of treatment already completed as on date:
(Please give full details dosages, changes in drug regimen, if any):

- a)Total duration of treatment
- b)already taken as on date
- c)3m/6m/9m/12m/18m/24m/30m/48m/54m/.

Contd...

4. Certified that the patient, whose particulars are given above, is suffering from..... and requires active treatment for a further period of approximately.month (s) to complete the treatment he/she is fit/unfit to attend normal duties/work and is/is not infectious to others.

Station.....

Dated.....

Signature and seal of the Attendant/MO
i/c case/Specialist/MS of Armed Forces/
MO of an Ord. Fy. Hospital

NOTE:-

1. This medical report should be completed in all respects. The report should be completed by a Cancer Specialist. In case the services of the Specialists are not available, the report should be completed by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medial Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital .
2. **Complicated Cases.** In case the treatment has been prolonged for over 4 years and or, in case of change of drug regimen detailed case notes may be given by a Specialist Medical Officer.
3. The case will be reviewed after every six months or after a period of treatment given in Para 4 by the medical authorities whichever is less.
4. **Documents required:**
 - i) The first application shall be made in the proforma given in Form-4.
 - ii) A duly attested copy of Biopsy/Histopathology/FNAC report as the case may be.

**APPLICATION FORM TO CLAIM NUTRITIOUS DIET ALLOWANCE
BY MEMBERS OF DCMAF FOR ANAEMIA DURING PREGNANCY
AND LACTATING MOTHER**

- ❖ Claim for Nutritious Diet Allowance for Anaemia during pregnancy and for Lactating Mother is admissible **for the first two children only**
- ❖ Claim for Nutritious Diet Allowance for Anaemia during pregnancy is admissible if **Haemoglobin is less than 10 mg%**

PART – I

1. Particulars of the Applicant:

- a) Name :
- b) Membership Card No :
- c) Designation/T.No./P.No. :
- d) Unit in which employed :
- e) Date of Joining the DCMAF (The date on which the first subscription was paid) :

PART – II

2. Particulars of the Patient:

- a) Name of the female beneficiary :
- b) Relationship with the member of DCMAF :
- c) Age of the female beneficiary :
- d) Details of living children:

S.No.	Name	Age	Sex
1			
2			
3			

Contd...

PART –III

3. Details regarding the Allowance requested:

- i) Reason for applying for Nutritious Diet Allowance ***Anaemia during Pregnancy/
Lactating mother**

*** If Nutritious Diet Allowance is requested for Anaemia during pregnancy :**

- a) Expected date of delivery :
- b) Haemoglobin status :
(Please attach a copy of the advice of the authorized Gynaecologist/AMA referring the patient for blood test. Blood report duly countersigned by the same Gyanecologist/AMA who advised blood test.)

*** If Nutritious Diet Allowance is requested for Lactating mother :**

- a) Date of birth of newborn baby :
(Please attach duly attested copy of date of birth certificate of the newborn baby with hospital's discharge note/slip)

Date :

Signature of the Applicant

*** Strike out whichever is not applicable**

PART – IV

4. **Certificate of the Admin Authority**

It is certified that the details given above have been checked with the available records in office and have been found to be correct.

The claim has been made for the ***first/second child.**

Date

Signature of the
Admin Authority
with Official Stamp

*** Strike out whichever is not applicable**

APPLICATION FORM TO CLAIM DIALYSIS ALLOWANCE
BY MEMBERS OF DCMAF

❖ Claim for Dialysis Allowance for Chronic Renal Disease

PART – I

1. Particulars of the Applicant:

- a) Name :
- b) Membership Card No :
- c) Designation/T.No./P.No. :
- d) Unit/Establishment in which employed :
- e) Date of Joining the DCMAF (The date on which the first subscription was paid) :

PART – II

2. Particulars of the Patient:

- a) Name of the patient :
- b) Relationship with the member of DCMAF :
- c) Date of birth of the Patient :
- d) Diagnosis (Pleases furnish detail case profile of the treating physician)

Date:

Signature of the Applicant

PART – III

3. Certificate of the Admin Authority:

It is certified that the details given above have been checked with the available records in office and have been found to be correct.

Date

Signature of the
Admin Authority
with Official Stamp

Contd...

PART – IV

**CERTIFICATE FROM THE TREATING PHYSICIAN IN CASE OF PERSONS
REQUIRING DIALYSIS**

It is certified that Sh/Smt/Mr/Ms _____, who is a case of _____ is on regular dialysis w.e.f. _____. Till now, he/she has received _____ dialysis and will be needing dialysis _____. (Frequency).

Hospital:

Date:

(Signature of treating physician with stamp)

NOTE:-

1. This medical report should be completed in all respects by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medical Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital .
2. **Documents required:**
 - i) Diagnosis
 - ii) clinical findings.

R E C E I P T

Received from Defence Civilians Medical Air Fund, New Delhi a sum of Rs.....
(Rupees.....only) for the month of.....for the
treatment of self/my.....who is suffering from.....

(Name of the disease)

2. During the preceding month the patient Mr./Mrs./Miss/Master
..... has been under the treatment of
.....

(here name the authorized hospital/clinic)

Station.....

.....
Signature of member of the Fund

Date.....

DETAILS OF BANK OF UNITS/ESTTS:

- (i) The official in whose favour Bank Draft to be issued.....
- (ii) Name of Bank of the Units/Public Fund Account.....
- (iii) Station.....
- (iv) Code number of the Bank.....

Reference DCMAF Sanctioned Letter No & Date.....

Membership Number

Name in (Block Letters)

Office Address

.....

D I R E C T I O N

1. Revenue stamp is to be affixed to this receipt, if the amount exceeds Rs. 5,000/- and above.
2. This receipt should be completed and dated in the same month for which the amount is being claimed.
3. Furnish **Life Certificate** of the member/dependents with this receipt .

NOTE:- payment of allowance will not be made if the pre receipt form is not found duly completed in all respects.

**APPLICATION FORM FOR GRANT OF SUBSISTENCE ALLOWANCE FROM THE
DEFENCE CIVILIANS MEDICAL AID FUND**

(Part – I)
(To be field in by the applicant)

- a) Name of the applicant (Member) _____
- b) Father's /Husband's name _____
- c) Membership Card No. _____
- d) Designation/T.No. _____
- e) Unit in which employed _____
- f) Date of Joining the Fund
(i.e. the date on which the Payment
of first subscription was made) _____
- g) Has he/she ever availed of the assistance
from the Fund in the past? If so, give
Letter No. of DCMAF _____
- h) Institution/Hospital where he/she was/
is receiving treatment (state period) _____

Station

Dated.....

Signature of applicant

(Part-II)
(To be filled in by the applicant Medical Attendant)

Certified that Shri..... Designation/T.No.....
of was/has been suffering from tuberculosis/cancer/leprosy / incapacitated
consequent upon an accident/ incapacitated consequent upon paralytic stroke and was recommended
..... Days leave from.....to.....

Date.....

Signature and seal of the Attendant/MO
i/c case/Specialist/MS of Armed Forces/
MO of an Ord. Fy. Hospital

Contd...

(Part-III)

(To be field in by the head of the Accounts Department/Unit of the Establishment)

Certified that Shri..... Designation/P.No..... of remained on Day's leave without pay and allowances from..... to.....

Dated.....

Signature and Seal of the Head
of the Accounts Office

(Part-IV)

(To be filed by the Head of the Establishment)

Recommended. The information furnished in parts I, II and III above has been verified and is confirmed. Duly attested copy/copies of the order(s) notifying the leave is/are enclosed.

No.....

Date.....

Signature & Seal of the Head
of the Establishment

NOTE:-

1. This medical report should be completed in all respects by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medial Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital .

2. **Documents required:**
 - i) Part – II Order notifying leave without pay and allowances granted to the member patient on medical certificate.

APPLICATION FOR EX-GRATIA GRANT FROM THE DEFENCE CIVILIANS MEDICAL AID FUND IN CASE A MEMBER PATINET DIES OF TB, CANCER, LEPROSY & HEART AILMENTS.

(To be filled in duplicate by the spouse/dependent son/daughter of the deceased member and parents, in case of unmarried member)

1. Particulars of the deceased:

- (a) Name :.....
- (b) Designation/P.No. :.....
- (c) Where employed :.....
:.....
- (d) Membership Card No. :.....
(To be enclosed with this application)
- (e) Disease suffering from :.....
- (f) Date of death :.....
- (g) Details of dependent family members:

Sl. No.	Name	Age	Relationship with the deceased	Marital status
1.....
2.....
3.....
4.....

2. Particulars of the applicant:

- a) Name :.....
- b) Age :.....
- c) Is he/she the legal heir/heirress of the deceased and/or was fully dependent on him/her :.....
- d) Does he/she also look after other dependent family/members of the deceased :.....
- e) Full Residential Address of the applicant
- f) Particulars of Bank details of the Applicant
 - (i) Branch name :.....
 - (ii) Code No.

Signature or Thumb Impression of the applicant (right hand thumb impression in case of females and left hand thumb impression in case of males)

Contd...

II

DEATH CERTIFICATE

(To be completed by the Authorized Medical Attendant of the Establishment or the Medical Officer of a Govt. Recognized Hospital or an authorized officer of the municipality/local body)

Certified that Shri/Smt. _____ of _____
(Here name the Establishment)

was suffering from TB /Cancer/Leprosy/Heart Ailments) and expired on _____ on account of the aforesaid disease.

Signature and Seal of the AMA of the Establishment /MS of Armed Forces/MO of an Ord. Fy. Hospital / Medical Officer of a Govt. recognized Hospital or an Authorized Officer of Municipality/local body

Dated.....

III

(To be filled in by the Head of the Establishment)

Certified that:

- (a) Late Shri/Smt..... was a Full Service member. Late Shri/Smt..... was Annual member of the Fund and had oncompleted one year's membership on the date of his/her demise.
- (b) The deceased had availed assistance for heart ailment from DCMAF (in case of death of heart patient)
- (c) The applicant is the spouse/dependent son/daughter/father/mother of the deceased.

Signature and Seal of the Head of the Establishment.

Dated:.....

PRE - RECEIPT

Received a sum of **Rs. 50,000/- (Rupees fifty thousand only)** on account of ex-gratia grant from the Hony. Secretary. Defence Civilians Medical Aid Fund.

Date:.....

Recipient's Signature or Thumb impression.

NOTE:-

- 1. Affix a revenue stamp as per rules.
- 2. **Documents required:**
 - i) A duly attested copy of death certificate from municipality/local body.
 - ii) A duly attested copy of Radiologist's/Histopathology/FNAC report on the basis of which the deceased was diagnosed to be a case of TB/Cancer/Leprosy if Nutritious Diet Allowance was not availed.
 - iii) Original membership card issued to the deceased member by the Fund
 - iv) If member patient dies due to heart ailments, confirmation whether member patient had availed assistance for heart ailments earlier, alongwith DCMAF letter number.

APPLICATION FORM FOR GRANT OF ADDITIONAL FINANCIAL ASSISTANCE FROM THE DEFENCE CIVILIANS MEDICAL AID FUND

1. PARTICULARS OF THE APPLICANT

- (a) Name
- (b) Membership card No.
- (c) Designation/ P.No.
- (d) Unit in which employed
- (e) Present basic pay
- (f) Date of joining the Fund (i.e. the date on which the payment of of first subscription was made

2. PARTICULARS OF THE PATIENT:

- (a) Name
- (b) Age
- (c) Relationship with the applicant
- (d) Does the income of the patient exceeds Rs.1500/- p.m (in case of dependent)?
- (e) Disease suffering from or having any particular disability
- (f) Institution / hospital where the patient was/ is receiving or will undergo treatment for the purpose
- (g) Is the application for nutritious diet for burn ? If yes, please furnish certificate from authorized Specialist / Orthopeadic Surgeon stating percentage of burns when admitted in hospital for treatment and period of further treatment of weeks/months is also required
- (h) Has the applicant availed of the benefits of the Fund at any time ? if so, give reference with DCMAF letter number

Contd...

3. **PLEASE TICK (✓) ONE OF THE FOLLOWING DISEASES FOR WHICH ADDITIONAL FINANCIAL ASSISTANCE / NON-REIMBURSABLE PORTION IS BEING CLAIMED:**

- | | | |
|---------|---|--------------------------|
| (i) | Procurement of blood for transfusion | <input type="checkbox"/> |
| (ii) | Implantation of Pace-Maker | <input type="checkbox"/> |
| (iii) | Hearing aid | <input type="checkbox"/> |
| (iv) | Crutches | <input type="checkbox"/> |
| (v) | Wheel Chair | <input type="checkbox"/> |
| (vi) | Prosthesis (Artificial Limbs) | <input type="checkbox"/> |
| (vii) | Cataract operation with Intraocular lens implantation | <input type="checkbox"/> |
| (viii) | Support-shoes (calipers) | <input type="checkbox"/> |
| (ix) | Neck-band | <input type="checkbox"/> |
| (x) | Procurement of Tricycle | <input type="checkbox"/> |
| (xi) | Nutritious diet allowance for burns | <input type="checkbox"/> |
| (xii) | Special Prosthesis for disabilities due to burns | <input type="checkbox"/> |
| (xviii) | Non-correctable blindness | <input type="checkbox"/> |
| (xiv) | Correctable blindness (other than Cataract) | <input type="checkbox"/> |
| (xv) | Loss of limbs i.e. arms & legs or eyes of the member patient in an accident | <input type="checkbox"/> |
| (xvi) | Coronary By-Pass surgery | <input type="checkbox"/> |
| (xvii) | Valve replacement | <input type="checkbox"/> |
| (xviii) | Renal transplantation | <input type="checkbox"/> |
| (xix) | Joint replacement with surgery | <input type="checkbox"/> |
| (xx) | Implantation of Stents | <input type="checkbox"/> |

4. **STATEMENT OF EXPENDITURE**

- | | | |
|-------|---|-------|
| (i) | Total expenditure | |
| (ii) | Expenditure Reimbursed from Govt. under CGHS/CSMA Rules | |
| (iii) | Non-reimbursed | |

(Please furnish a duly attested copy of final payment order of CDA in case the expenditure in full or part was reimbursed by the Govt. to the member under CGHS/CSMA Rules)

Contd...

Part - I

CERTIFICATE

(To be completed by the Head of the Establishment)

5. Recommended. The information furnished at item Nos. 1 to 4 above has been verified and is confirmed as correct.

Station :

Signature and Seal of the
Head of the Establishment

Date:

Part - II

6. Certified that Shri /Smt.aged years
Self/Father/Mother/Son/Daughter/Husband of Shri/Smt.....(member's
Name).....is/was suffering from..... (disease mentioned
in Para 3 of this Form) . The total expenditure involved in this connection was Rs. (.....)
(.....only)
(in words)

Station :

Signature Name & Office Seal of
the Specialist/ MO i/c

Date :

(To be completed and signed by / Medical Specialist /Cancer Specialist / Cardiologist or Cardiac Surgeon / Orthopedist / Ophthalmologist or ENT Specialist (as the case may be) attached to a Govt./Govt. recognized Hospital including an Ordnance Factory Hospital)

NOTE: -

1. The medical reports should be completed and authenticated in all respects by one of the following medical authorities:
 - a) Medical Officer of a Govt/Govt Recognised hospital
 - b) Authorized Medical Attendant of the Establishment
 - c) Medical specialist of the Armed Forces
 - d) Medical Officer of an Ordnance Factory hospital
2. **Documents required:**
 - i) Case profile of the patient.
 - ii) Original /attested copy of the cash memo in case of IOL / Hearing Aids / Crutches / Wheel Chair etc.
 - iii) Copy of final payment order from CDA, where partial reimbursement has been made by the Govt. under CGHS/CSMA Rules.
 - iv) Blood Bank's Cash memo in case of procurement of blood for transfusion in various ailments including Leukemia and Bone Marrow Transplantation.

**APPLICATION FOR EX-GRATIA GRANT FROM THE DEFENCE
CIVILIANS MEDICAL AID FUND IN CASE A MEMBER PATIENT
DIES IN AN ACCIDENT.**

(To be filled in duplicate by the spouse/dependent son/daughter of the deceased member and parents, in case of unmarried member)

1. Particulars of the deceased:

- (a) Name :.....
- (b) Designation/P.No. :.....
- (c) Where employed :.....
- (d) Full Service Membership/Annual Membership Card No. & Date (To be enclosed with this application) :.....
- (e) References under which Annual Subscription have been remitted to the Fund for last 10 years :.....
- (f) Cause of accident :.....
- (g) Date of death :.....

g) Details of dependent family members:

Sl. No.	Name	Age	Relationship with the deceased	Marital status
1.....
2.....
3.....
4.....

2. Particulars of the applicant:

- (a) Name :.....
- (b) Age :.....
- (c) Relationship with the deceased member :.....
- (d) Is he/she the next of kin of the deceased Member :.....
- (e) Full Residential Address of the applicant :.....
- (f) **Particulars of Bank A/C**
 - (i) Name of the Bank :.....
 - (ii) Branch name :.....
 - (iii) Code No. :.....
 - (iv) Account No. :.....

Signature or Thumb Impression of the applicant (right hand thumb impression in case of females and left hand thumb impression in case of males)

Contd...

II

(To be filled in by the Head of the Establishment)

- (a) Certified that Late Shri/Smt.....was working in this Establishment met with an accident and expired on..... on account ofaccident.
- (b) Late Shri/Smt.....was a Full Service Member/Annual Member of the Fund having FSM/Annual Card No.....Annual subscription of the deceased had been remitted to the Fund vide para 1(e).
- (c) The applicant is the spouse/dependent son/daughter/father/mother of the deceased.

Dated:.....

Signature and Seal of the
Head of the Establishment.

III

PRE - RECEIPT

Received a sum of **Rs.50,000/- (Rupees fifty thousand only)** on account of ex-gratia grant from the Defence Civilians Medical Aid Fund (DCMAF).

Date:.....

Recipient's Signature or Thumb impression

Note:- Affix a revenue stamp as per rules.

Please attach the following documents:

- (i) Attested copy of Post Mortem Report
- (ii) A copy of FIR lodged
- (iii) Attested copy of Death Certificate issued by Municipality/Local Body
- (iv) Photocopy of Ration Card
- (v) Original Membership Card