APPELLATE TRIBUNAL FOR ELECTRICITY

FORM OF APPLICATION FOR REIMBURSEMENT OF MEDICAL CLAIM

1. Name and Designation .... : ____________________
2. Basic Pay + Dearness Allowance .... : ____________________
3. Name of the patient and relationship .... : ____________________
4. Place at which patient fell ill .... : ____________________
5. Name of the Doctor/Hospital .... : ____________________

<table>
<tr><th colspan="4" rowspan="2">CLAIM DETAILS</th><th colspan="2">AMOUNT CLAIMED</th><th colspan="2">AMOUNT ADMITTED</th></tr>
<tr><th>Rs.</th><th>P.</th><th>Rs.</th><th>P.</th></tr>
<tr><td>a.</td><td colspan="3">Consultation Charges:
number and dates of consultations</td><td></td><td></td><td></td><td></td></tr>
<tr><td>b.</td><td colspan="3">Special Consultation:
number and dates of consultations (Minor procedure OT)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>c.</td><td colspan="3">Pathological Charges:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>d.</td><td colspan="3">Cost of Medicines</td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>S.No.</td><td>Cash Memo No.</td><td>Date</td><td></td><td></td><td></td><td></td></tr>
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<tr><td></td><td></td><td></td><td>Total</td><td></td><td></td><td></td><td></td></tr>
</table>

I hereby declare that the statements in the application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

Date:

Signature of the Employee