

## Indian Officers Working on FOSMA / MASA Agreement

Claim Notice Sent on \_\_\_\_\_ M.F.S.W.T.No. \_\_\_\_\_ CLAIM No. \_\_\_\_\_

### The Maritime Floating Staff Welfare Trust (for Office Use)

69, Bajaj Bhawan, 6<sup>th</sup> Floor, Nariman Point, Mumbai – 400 021.

Tel. : 2202 5705 • Telefax : 2202 5706 • Email : mfswt@vsnl.net

## STATEMENT OF CLAIM FOR HOSPITALISATION TREATMENT

Name of Last Company Vessel .....

Sign on ..... Sign off .....

Date of Rejoining From Leave .....

Name of Company Rejoined .....

MUI Membership No. .... Valid Till .....

(IN CAPITAL LETTERS)

PARTICULARS OF CLAIM	PARTICULARS OF OFFICER
Name of the Patient _____	Name _____
Date of Birth _____	Surname _____ Name _____ Father's Name _____
Relationship _____	Company _____ Rank _____
Nature of illness _____	Whether covered under approved CBA _____
Is the dependent patient employed? YES/NO.	Date of Joining _____
Name of Employer _____	Authorised Leave from _____ to _____
_____	Unemployed Since _____

Home Address :- \_\_\_\_\_

Tel No.: \_\_\_\_\_

Particulars of Bank A/c :- (Not N.R.E. / NRI Account) Email : \_\_\_\_\_

Name of A/c. holder \_\_\_\_\_ Account S.B. or NRO A/c. No. \_\_\_\_\_

Name of the Bank \_\_\_\_\_

Name of the Branch \_\_\_\_\_ Address \_\_\_\_\_

1. **In case of Accident** : Answer the following.
  - (a) When did the accident happen ?  
Date \_\_\_\_\_ Time \_\_\_\_\_
  - (b) Give brief description of accident \_\_\_\_\_  
\_\_\_\_\_
  
2.
  - (a) I/my wife/child have/has not received any medical/financial aid from any source.
  - (b) My wife in respect of herself/child has received financial assistance to the extent of  
Rs. \_\_\_\_\_ from her employers.  
Messers \_\_\_\_\_  
Address \_\_\_\_\_

3. Last claim made on the **Maritime Floating Staff Welfare Trust** in respect of any member of family under claim No. \_\_\_\_\_ Date \_\_\_\_\_ for Rs. \_\_\_\_\_
4. Total amount of this claim is Rs. \_\_\_\_\_ (Rupees \_\_\_\_\_)
5. I hereby declare that the foregoing and the details of treatment and expenses incurred as given above are true in every respect and are made without any reservation. I have not signed off on medical grounds.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Employee (in his absence his wife)

**IMPORTANT** : PLEASE DO NOT LEAVE ANY ITEM BLANK AND ATTACH ALL BILLS, RECEIPTS, CERTIFICATES, PRESCRIPTIONS, REPORTS & CASH MEMOS FOR MEDICINES.

**Details of Treatment and Expenses**

**A. Hospital Charges :** (Room, Board and Ordinary Services)

Admission/Registration Charges Rs. \_\_\_\_\_

Admitted to Hospital on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.

Discharged on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.

Charges for \_\_\_\_\_ days at Rs. \_\_\_\_\_ per day Rs. \_\_\_\_\_

Total \_\_\_\_\_ Rs. \_\_\_\_\_

Under Medical care of Dr. \_\_\_\_\_

from \_\_\_\_\_ upto \_\_\_\_\_

**Other Charges**

<b>B Name and Address of the Hospital/Nursing Home</b>	1 Operation/Delivery Room .. ..	Rs. _____
	2 Oxygen, Blood Transfusion .. ..	Rs. _____
	3 Laboratory .. ..	Rs. _____
	4 X-Ray .. ..	Rs. _____
	5 ECG, BMR .. ..	Rs. _____
	6 Drugs & Dressings From Hospital ..	Rs. _____
	From Market ..	Rs. _____
7 Others .. ..	Rs. _____	
		Rs. _____
		Rs. _____
		Rs. _____
		_____
		Total _____

**C Surgeon's Fees :** (To be completed by the Surgeon/Gynaecologist)

1 Patient's Name \_\_\_\_\_ Age \_\_\_\_\_  
Nature of Surgical or Obsterical Procedure \_\_\_\_\_  
Operation Performed at \_\_\_\_\_ Date \_\_\_\_\_  
Charge for the above procedure Rs. \_\_\_\_\_ (Rupees \_\_\_\_\_)  
Anaesthisist's Fees Rs. \_\_\_\_\_ (Rupees \_\_\_\_\_)  
Signature \_\_\_\_\_  
Date \_\_\_\_\_ Surgeon/Gynaecologist  
Address \_\_\_\_\_

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**D Consultant's Fees :** (To be completed by the Physician/Consultant)

1 Name of Patients \_\_\_\_\_ Age \_\_\_\_\_  
2 Diagnosis \_\_\_\_\_  
3 Consultation on (Date/s) \_\_\_\_\_ @ Rs. \_\_\_\_\_  
\_\_\_\_\_ @ Rs. \_\_\_\_\_  
Total Rs... \_\_\_\_\_

I certify that I had advised the above patient to get admitted in the Hospital &

I had recommended the service of Special Nurse / Ward boy.

(  To be struck off if not applicable.)

Clinic Stamp is required

Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician/Consultant

Address \_\_\_\_\_  
\_\_\_\_\_

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**IMPORTANT :** (1) Entries in Sections A, B, C & D must be supported by all original Bills and receipts from the respective parties i.e. Hospital, Surgeon/Anaesthisist Physician, Consultant and prescriptions and each memos for medicines. (2) In case of Operation/Delivery part 'C' must be completed and signed by Surgeon/Gynaecologist. In other cases part 'D' must by signed be the Consultant/attending Physician. For delivery claim, to attach photocopy of the child's Birth certificate / Hospital Discharge Card. (3) Prescriptions should clearly show the name of patient, Date, Name and quality of medicines. (4) cash memos should clearly indicate the name of patient and name of Doctor. (5) Claim form should be submitted as early as possible but not later than six months. (6) Relevant page of your C. D. C. including name page, should be attached. (7) unsigned form will be returned.

**PLEASE ATTACH PROOF (XEROX COPIES) OF YOUR IMMEDIATE LAST / PRESENT EMPLOYMENT**