

Indian Officers Working on FOSMA / MASA Agreement

Claim No. _____

M.F.S.W.T.No. _____

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

69, Bajaj Bhawan, 6th Floor, Nariman Point, Mumbai – 400 021.

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

MEDICAL SCHEME

Name of Last Company Vessel
Sign on Sign off
Date of Rejoining From Leave MUI Membership No.
Name of Company Rejoined

CLAIM FOR DOMICILIARY TREATMENT

PARTICULARS OF CLAIM (IN CAPITAL LETTERS)	PARTICULARS OF OFFICER
Name of the Patient _____	Name _____
Date of Birth _____ Relationship _____	Surname _____ Name _____ Father's Name _____
Nature of illness _____	Company _____ Rank _____
Is the dependent patient employed? YES/NO.	Whether covered under approved CBA _____
Name of Employer _____	Date of Joining _____
_____	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 N.R.O. A/c. No. _____

Name of the Bank _____

Name of the Branch _____ Address _____

- (5) Claim form completed in all respects should be sent immediately on fitness after the treatment is over.
- (6) Separate claim form should be submitted for each person and for each illness.
- (7) Please attach Xerox copy of your proof of employment & copy of name page & relevant page of voyage engagement & discharge from your C.D.C.
- (8) Unsigned forms will be returned.

CERTIFICATE TO BE SIGNED IN CLAIMS OF CHILDREN

Certified that my son/daughter _____
 age _____ is unmarried, unemployed and solely dependent on me.

Date : _____ OFFICER/WIFE

WORKING FOR OFFICE USE ONLY.				Summary details – Amount Payable DETAILS
Consultations	Investigations	Medicines	Total Claimed	
_____	_____	_____	_____	Consultation :
_____	_____	_____	_____	Investigation :
_____	_____	_____	_____	Medicine :
_____	_____	_____	_____	Total Amount Payable _____

Remarks:-