

Indian Officers Working on FOSMA / MASA Agreement

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

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 WELFARE SCHEME HEALTH STATEMENT

(To be filled in by the Officer for once only and to be submitted to the 'Trust' immediately)

To,

The Maritime Floating Staff Welfare Trust
Mumbai.

Name of Last Vessel of Company
Sign on Sign off
Date of Rejoining From Leave
Name of Company rejoined
MUI Membership No Valid Till

I give below particulars of the members of my family and the state of their health. The Statements made and answers given herein are correct and wholly true and it is understood and agreed that these are the basis on which reimbursements may be granted to me by Medical Scheme. I further agree that if it is found that the statement and answers are in any respect incorrect or untrue, the Medical Scheme shall be under no obligation to pay any claim made by me or, if any payment has been made, I shall be liable to reimburse the The Maritime Floating Staff Welfare Trust the amount paid to me on any claim.

1. Officer's full name : _____

Surname Name Father's Name

2. Designation : _____ 3. Present Company employed in : _____

4. Date of employment : _____
(Initial Employment)

5. Particulars of Service during the last 4 years with dates : _____

Name of Vessel	Name of Company	Signed on	Signed off
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Residential Address : _____

Tel. No.: _____

Email : _____

7. Name of your family Doctor, his qualifications and address : _____

8. Are you, and members of your family given below, in good health ? if not, mention specific ailments : _____

9. Are you, your wife and/or children covered with any Insurance Company under any Medical Scheme ?

if so name the Company / ies, type and amount of coverage : _____

10. Is your wife gainfully employed ? If so give particulars of her employment : _____

11. Bank Accounts Details : (Please do not give your N. R. E. /NRI Account details)

Name of A/c. Holder _____ Account No. _____

Name of the Bank _____

Name of the Branch _____ Address _____

12. Wife's signature for verification of medical claims :

13. PARTICULARS OF FAMILY MEMBERS :

Name in Full (BLOCK LETTERS)	Relationship	Date of Birth	Height	Weight
1. Mr. _____	Self			
2. Mrs _____	Wife			
3. _____	Children			
4. _____	- do -			
5. _____	- do -			

I hereby certify and declare that the above details are true to the best of my knowledge and belief.

I have received a copy of the Medical Brochure and Claim Forms.

Place :

(Signature of Officer)

Date :

Designation :

Company :