STATE BANK OF INDIA
RETIRED EMPLOYEES MEDICAL BENEFIT TRUST
CLAIM FOR REIMBURSEMENT OF DOMICILIARY TREATMENT

01	Name of the Retired Employee (member pensioner)	
02	Date of Retirement PF Number :	
03	Whether claimed for self/Spouse	
04	Address & Telephone No	
05	Retired as	
06	Pension Paying Branch SB A/c No	
07	Nature of Illness	
08	Name of the dependent family member for whom the Medical Expenses made Name Age Relationship	
9	Duration of Illness	
10	Name & Address of the attending Physician	
11	Claim Amount	

I certify that I have incurred above expenses for myself & / eligible family members

Signature of the pensioner member

Forwarded for payment