

STAFF BENEFIT FUND
CLW/CHITTARANJAN

APPLICATION FOR ASSISTANCE FROM SBF TOWARDS COST OF SPECTACLES

Notice No. MW/WEL/SBF/SPECT Dated:-

1.	Name of the Employee			
2.	Designation		T/No.	
3.	Control No.	Bill Unit No.	Community SC/ST	
4.	Basic Pay	Whether assistance received for self /family member in last three years		
5.	For whom assistance is required			
6.	Date of purchase of Spectacles			
7.	Cash Memo No. & Amount (ORIGINAL CASH MEMO TO BE ENCLOSED)			
8.	Medical Identity Card No. (Photocopy of Medical Identity card to be enclosed)	Mobile No.		

Details of the bank account of the employee

Photocopy of first page of bank passbook to be enclosed)

Account number		IFSC	
Bank & Branch			

I declare that I have not claimed assistance from SBF towards the cost of spectacles during the last 03 (three) Financial Years. The particulars furnished by me above are true and I am liable for disciplinary action if proved untrue.

Enclosures:

1. Original Cash Memo
2. Xerox copy of prescription
3. Xerox copy of Medical Identity Card
4. Xerox copy of Pay Slip
5. Photocopy of first page of bank passbook to be enclosed

Date:

Signature of Applicant

Forwarded to AWO & Secy./SBFMC – Certifying the above particulars.



Signature of Section In-charge

Signature of Controlling Officer