APPICATION FOR MEDICAL AID

(One time benefit by BCI- will not be deducted by KSBC in final Death or Retirement Claim Benefits)

PHOTO

To,
The Secretary,
Bar Council of India-Advocates' Welfare Committee for Karnataka,
Karnataka State Bar Council, Old K.G.I.D Building, Bangalore -01

Phone No. (080) 22868712/22868561. Mob. No. _____

Sir, I, _____ Advocate S/o. _____ furnishing hereunder the particulars required and request for grant of financial assistance.

1.	NAME (IN CAPITAL LETTERS)	
2.	ADDRESS	
3.	ROLL NO. & DATE	
4.	PLACE OF PRACTICE	
5.	AGE & DATE OF BIRTH	
6	NATURE OF ILLENSS, DISABILTIY WITHIN THE DEFINTION OF SERIOUS AILMENT	
7	NAME OF HOSPITAL, PLACE & DURATION OF TREATMENT	
8	TOTAL AMOUNT SPENT FOR TREATMENT AS PER MEDICAL BILLS	
9	WHETHER CERTIFIED FROM THE PRESIDENT OF CONCERNED BAR ASSOCIATION	
10	ANY DOCUMENT	

PLACE :
DATE : SIGNATURE OF THE APPLICANT

VERIFICATION

I,_____ the applicant above named do hereby solemnly state and declare that what is stated above is true and correct to the best of my knowledge belief and information.

SIGNATURE OF THE APPLICANT

Rule 3(VI) of the Bar Council of Advocates' Welfare Fund Scheme :

"Serious Ailment" means undergoing amputation of limbs, suffering from paralysis, affecting mobility or speech, bye-pass /open heart surgery/angiography, failure of the kidney, suffering from cancer, HIV/AIDS, brain tumour, mental disorder, liver cirrhosis requiring hospitalisation.

CERTIFICATE

I, _____, the President, Bar Association _____ certify that Sri/Smt. _____, Advocate who has applied for financial assistance from the Advocate Welfare Fund is a member of this Bar Association, actively practicing at _____ and since he/she is suffering from ailment, requiring medical treatment / disable to practice, I recommend for grant of financial assistance.

SIGNATURE & SEAL OF THE BAR ASSOCIATION

PLACE :
DATE:

PRE-RECEIPT

Received a sum of Rs. _____ (in words) _____ Only) from the Secretary Advocates Welfare Committee for Karnataka State Bar Council, Bengaluru towards financial assistance granted by the Committee on my application.

SIGNATURE OF THE APPLICANT

PLACE :
DATE:

NOTE : Notarised Medical Bills & Medical Certificate / Discharge Summary, Indemnity should be produced alongwith Claim application, with duly filed with details.

ANNEXURES

FORMAT OF THE AFFIDAVIT

(On Non-Judicial Stamp Paper of the Value of Rs. 100/-)

This deed of indemnity bond executed this_____ day of _____ by Advocate Sri. _____ hereinafter called the applicant in favour of the Bar Council of India Advocates' Welfare Committee having its office at the office of the Karnataka State Bar Council, Old K.G.I.D Building, Bengaluru-1.

Whereas , the above said applicant has applied for the Financial Assistance from the said committee which has to consider the claim of the applicant and pass after enquiry necessary order granting financial assistance.

Whereas, it has become necessary to file the Indemnity bond as required under the rules.

I hereby declare that in case the particulars and document furnished by me is found to be false or contains false information, the Bar Council Committee is at liberty to initiate appropriate legal proceeding against me including proceedings for misconduct.

In the event of Bar Council / Committee, revoking the order of payment of compensation, after making the payment. I undertake to repay the same alongwith interest at the rate of 12% p.a.

The applicant has executed this indemnity bond in favour of the Committee, agreeing to indemnify the payment made towards such financial assistance to the applicant by the Committee in the event of the amount so paid has been obtained by the applicant by fraud, misrepresentation, false claim and further agreeing that the applicant shall be liable for all the consequences arising our of such fraud, mis-representation and false claim.

In witness whereof the applicant has set his hand and signature on _____ day of _____

WITNESSES

1.

2. **Signature**

MEDICAL BILLS STATEMENT

NAME OF THE ADVOCATE :

NAME OF THE HOSPITAL TAKEN TREATMENT :

PLACE :

Sl.No.	Bill No.	Bill Date	Amount