EMPLOYEES' TRUST FUND BOARD

Application for Reimbursement of Expenses under "Shramasuwa Rekawarana" Hospitalization medical Insurance Scheme

For office use only

Part I [To be completed by the member]

01. (a) Full Name of member .....
.....
(b) name with Initials:
.....

02. Address ;.....
.....Tel no; .....

03. Date of Birth:..... 04. NIC No.....

05. Please give below details of employers you worked with during the past five years, including the present employer:

Date of joining	Date of leaving	Name of Employer	EPF/PPF Registration No.	Employee (Membership) No.

05. Details of hospitalization:

(a) Illness/accident:.....
(b) Date the illness set in or the accident occurred :.....
(c) (i) Date and time of admission to hospital:.....
(ii) Date and time of leaving hospital :.....
(d) Name of the hospital where treatment was obtained:.....

06. Bank account details [since payment is made by cheque, it is essential that the applicant has a bank account]

Name of Bank : .....
Branch : .....
Type of Account [Joint /Savings / Current]:.....
Account No ; .....

07. Total cost of treatment Rs: .....

08. If part of the total cost of treatment is reimbursed by the employer please state the amount Rs: .....

09. If part of the cost of treatment is reimbursed by any other Institution or Insurance Company please state the details below;

Institution	**Amount (Rs)**

I hereby declare that I obtained hospitalized treatment for the illness/ accident described in this application during the period stated, and that the amount paid to the hospital is correct. I am aware that I am liable to be prosecuted in a Court of Law if the information given by me is found to be false.

Thumb impressions of member.

Left Right

.....
Signature of Member

Date : .....

Telephone No.....

Part II [To be completed by the General Practitioner / Surgeon/ Physician who treated the patient]

(a) Name of patient :.....

(b) Condition that required investigation or treatment:.....
.....

(c) Diagnosis of disease: .....

(d) Details of treatment or operation;
.....
.....

(e) State briefly the history of injury or ailment:
.....
.....
.....

.

(f) Period the patient is unfit for work or needs rest:
From: .....To.....

(g) State approximately when, in your opinion, the ailment could have BEGUN or CONTRACTED by the patient:
.....
.....

(h) Date of admission:..... Date of discharge:.....

I certify that I am the General Practitioner / Surgeon / Physician who treated the patient referred to above and confirm that the above details are true and correct.

Date **;.....** **.....**

Signature & Seal of
Medical Practitioner /Surgeon / Physician

Name of Medical P0ractitioner /Surgeon / Physician;.....

Qualification;.....

Address ;.....

Telephone No:.....

N.B. To completed by the Surgeon in all cases of surgical treatment.

Part III **[**To be completed by the Employer**]**

01. I, ... the Manager / Partner / Director/ Proprietor* of .....
(name of establishment)
.....at .....
(address)
.....hereby certify that Mr / Mrs / Miss*
.....
bearing EPF/PPF No..... and having NIC No.....
has been an employee of this establishment from ..... to date, and that he/she was on sick leave from ..... to .....

02. We further certify that we have remitted ETF contributions on behalf of this employee up-to-date. We give below details of ETF contributions remitted in respect of all our employees, including this employee, for the 12-months prior to the month in which the hospitalization.

Month	**Total contribution remitted for the month**		**Date of Payment**	**Cheque No.**
	This employee	**All employees**		

03. Please state whether contributions for the above period were made through Form R1 or For R4;.....

04. If contributions are remitted through Form R1, Form II returns for the relevant period [please tick relevant cage]

i) Have already been sent to the ETF and his / her* name has been included in the return. ☐

ii) Is to be sent in due course and his/her* name will be included in the return. ☐

I do hereby declare that the foregoing facts are true and accurate. I am aware that if I furnish any false information I shall be liable for prosecution in a Court of Law under Section 39 of the Employees' Trust Fund Act.

Date :.....

.....
Signature of Employer

* *Please delete whichever is inapplicable*

Seal

Telephone No:

Eligibility criteria for benefits

Following are the requirements for benefits under the Shramasuwa Rekawarana Hospitalization Medical Insurance Scheme;

1. A member applying for benefits should be an active member contributing to the Fund as at the date of admission to hospital. In addition, the member should have been a contributing member for a period of five consecutive years.
2. The employer should have remitted contributions to the Fund on behalf of the member for a period of twelve months prior to the month in which hospitalization occurs.
3. Of the 12 month period referred to above, contributions for six months should have been duly paid before the prescribed date.
4. The member should be not more than 70 years of age.
5. Those members who have already obtained hospitalization expenses reimbursed up to Rs. 50,000/- are not eligible to claim benefits under the scheme.
6. It is necessary to be in hospital for a minimum period of 48 hours to qualify for benefits.

Instructions/documents to be submitted

1. The applicant should fill Part I of the application while Part II should be completed by the medical practitioner. The employer should complete and certify Part III.

2. The application should be forwarded to this office along with all relevant documents within sixty days from the date of discharge from hospital. Incomplete, incorrectly filled and delayed applications will not be accepted.

3. Expenses incurred for treatment as an outpatient will not be reimbursed.

4. Originals of all prescriptions bills and receipts must be forwarded with the application. Photocopies of the following documents certified by the employer should also be forwarded with the application.
   - * Diagnosis Card issued by the hospital
   - * National Identity Card of the member
   - * Bank passbook [pages showing account number, account holder, bank and the branch etc.]

5. A letter from employer giving details of any amount given to contribution to a part of the hospital bill, and if the employer has recovered any amount so contributed.

6. If part of the bill is reimbursed by another institution, a letter issued by the institution stating the amount reimbursed.

7. A member can only claim up to Rs. 50,000/- under this scheme during his/her career. The maximum that can be claimed in a year is Rs. 25,000/- [room charges Rs. 5,000/- plus Rs. 20,000/- for other items].

8. In case of those members who have left employment but not withdrawn their ETF contributions in respect of previous employment , such period of service will be considered as a period of membership.

9. The decision of the Board on the payment of benefits under this scheme shall be final.

Manager [Benefits Administration]
Employees' Trust Fund Board
Labour Secretariat
COLOMBO 5.

Tel. 011-2581704

IMPORTANT

The scheme covers the following categories of hospitals;

- Government hospitals
- Government Ayuarveda hospitals
- Registered private hospitals approved by the Board.

This application is not valid in respect of Heart Surgeries, Kidney Transplants and Intra-ocular Lens Transplants.

Surcharges imposed on employers for delayed payment of contributions will disqualify claimants from availing of benefits under this scheme.

Applications that do not accompany required documents, bills and receipts and applications submitted later than the specified period will be rejected.

Reimbursement will not be considered in the following cases:

- Attempted suicide.
- Mental illnesses
- Ailments caused by using alcohol and drugs
- Venereal diseases
- Conditions associated with infection of HIV [AIDS]