SRI LANKA AIR FORCE
GAGANA SUWA SAVIYA (GSS) SCHEME CLAIM FORM- RETIRED MEMBERS

SECTION 'A' TO BE FILLED BY THE MEMBER

Details of the Member

1. Service No :…… Rank:…….
   Name with Initials :…….
2. SLAF F.1250 No :……Contact No(Mobile): ……
3. Parent Station :…… Formation/Section:…….
4. Marital Status :…….
5. Nearest Air Force Station declared:……..

Details of the Beneficiary

6. Name with Initials.....…….....…….
7. Relationship…… Age:…… …….
8. Employment Status: Employed/Unemployed
9. Description of the sickness by patient :…….……..……..
   ……..
10. Place where treatment obtained from:……..……
11. Name of the Medical Practitioner/Consultant from whom treatment was obtained:…..…….
    ……..……

Details of Supportive Documents

12. Bills:

Bill No	Folio No	Amount
1		
2		
3		
4		
5		
Total		

13. Following documents are attached to this form:

Copy of diagnosis card	Attached	Not attached
Prescriptions (number the prescription if more than one)		
Consultant's comments		

14. I hereby declare that:
    a. I am a member of the SLAF Medical Welfare Scheme
    b. The particulars entered above are certified correct
    c. I am liable to refund any sum paid to me/my family if the details given by me found to be false.

Date:…….. ……

(SIGNATURE OF THE APPLICANT)

SECTION 'B' TO BE FILLED BY ACADEMY/BASE/STATION MEDICAL OFFICER

1. Diagnosis :…….....….....
2. Name and the specialty of the Medical Practitioner:…..…….....……
3. From which claim category the payment has to be made:

Bill No	Claim category	Amount
1		
2		
3		
4		
5		

4. Authority to claim the expenditure obtained from:…….....……

Date:…… ……..……..

(SIGNATURE OF THE MEDICAL OFFICER)

…

Claim Category	Expenditure Incurred	Annual Limit (Rs.)	Amount granted
Drugs-Dressing Consultation		3500/=Event 35000/= per annum	
Investigation		25000/=	
In-ward –medical Room charges Other expenses		Overall upper limit 200,000/= per annum 7000/=day Max 14 days	
In-ward –Surgical Room Charges Other expenses		500,000/= per annum 7000/= per day Max 14 days	
Ayurvedic Treatment Out patient In-ward		 5000/= 20000/=	
Special Payment for Hospitalization at Government Hospitals		500/= per day maximum 30 days	

…….
(TREASURER SIF)
ACADEMY/BASE/STATION

…….....
TREASURER
CWF

SECTION "D" TO BE FILLED BY THE BASE COMMANDER/COMMANDING OFFICER

1. I confirm that I have ascertained the veracity of the facts stated in the application.
2. Payment of Rs..... (Rs..... .....)
is Recommended/Not Recommended/Approved/Not Approved.

Date :-.....

.....
(CMDT/BASE CMDR/CO)

SECTION "E" TO BE FILLED BY THE DIRECTOR HEALTH SERVICES (APPROVAL FOR CLAIMS UPTO RS. 50,000.00)

1. I confirm that:
   a. The details the sickness/surgery are correct as per the medical records.
   b. The bills submitted by applicant are for treatment related to this particular sickness/surgery.
   .....
   .....
   c. Payments of Rs:.....
   (Rs. .....) is Recommended/Not Recommended/Approved/Not Approved

(.....)
DGHS

Date :.....

SECTION "F" TO BE FILLED BY THE CHIEF OF STAFF (APPROVAL FOR CLAIMS FROM RS. 50,000.00 UP TO RS. 100,000.00)

Payment Approved/Not Approved

Date :-.....

(.....)
COF S

SECTION 'G'

APPROVAL OF THE COMMANDER (APPROVAL FOR CLAIMS BEYOND RS. 100,000.00)

Payment Approved/Not Approved

Date :-.....

(.....
COMMANDER OF THE AIR FORCE

SECTION 'H'

Payment/Re-imbursement made through slip transfer system of People's Bank Headquarters for Rs…….
payment effected on.....20.....

Date:- .....

(…….....)
TREASURER
CWF