Advocate's Mobile No. ……

Residence No. with STD code. …….

To,
The Secretary,
K.A.W.F. – T.C.
Bangalore - 1

Photo

FORM NO. IX

[See Section 16(A) and rule 15]

APPLICATION FOR PAYMENT FROM THE FUND IN CASE OF

MEDICAL CLAIM

1.Name	
2. Address	
3. Roll No. & Date	**Mys/Kar:** **Date :**
4. Age & Date of Birth	
5. Date of Admission to the Fund	
6. Details of Ailment	
7. Whether applicant was hospitalized if so, furnish Name of the Hospital	**Yes/No**
8. Date of Admission & Date of Discharge	**From:** **To :**
9.Duration of treatment (In case of out Patient)	**From:** **To :**
10 Total amount spent	**Rs.**

I hereby declare that the statements made above are true and I believe them to be correct.

The amount paid to me from the Welfare Fund is liable to be deducted out of the amount due to me at the time of making final settlement. If the information given by me is false of incorrect, I will be liable to refund the amount with interest.

Date :

Place: **Signature of the Advocate**

Mobile No.

CERTIFICATE OF THE PRESIDENT

I…… the President of ……Bar Association do hereby certify that Shri/Smt…… is an Advocate practicing at …….

PLACE: **PRESIDENT**

DATE : **SEAL**

DOCUMENTS REQUIRED

(1) An affidavit on a (Stamp paper value of Rs.50/-) in the prescribed form duly attested by the Notary public or the Magistrate. (Format enclosed)
(2) An attested copy of the Discharge Summary,
(3) An attested copy of the certificate issued by the Doctor who has treated the applicant which shall contain the nature of illness, details of treatment and other details. (In case of out patient)
(4) Attested copies of medical bills/receipts in respect of the amount actually spent.
(5) Xerox copies of Enrollment & Welfare Fund Certificate.
(6) Original cancelled cheque of the Nominee/Claimant.

RECEIPT

Received today a sum of Rs. …… from the KAWF towards Medical Claim under section 16(A) of the KAWF Act 1983 vide TCM Dated: …….

Date :

Place: **Signature of the Advocate**

KARNATAKA STATE BAR COUNCIL
KARNATAKA ADVOCATES WELFARE FUND TRUSTEE COMMITTEE
BANGALORE

MEDICAL BILLS DETAILS

ADVOCATE NAME :

Sl.No.	Bill No.	Date	Amount

IN SUPPORT OF APPLICATION CLAIMING MEDICAL RELIEF

I, _____ S/o. _____ Major, Occupation : Advocate, residing at _____ _____, Bangalore District do hereby solemnly affirm and state as follows :

1. I am an Advocate practicing in the State of Karnataka and my name is there on the rolls of Karnataka State Bar Council as on this date. I have made contribution in full and I am a member of Karnataka Advocates' Welfare Fund.
2. I have made an application seeking medical relief as I am suffering from serious ailment as defined in section 16(A) of the Karnataka Advocates' Welfare Fund Act.
3. The amount payable under Section 16(A) towards medical claim shall be deducted out of the amount due to me at the time of making final settlement as per the schedule or section 16(1).
4. I hereby declare that the information given in the application accompanying this affidavit claiming medical relief is true to the best of my knowledge and information and I hereby state that in case the particulars in the application are false or the documents produced along with the application are found to be false or contain false information, the Bar Council / Committee is at liberty to initiate appropriate legal proceedings against me including proceedings for misconduct.
5. In the event of Bar Council / Committee, revoking the orders of payment of medical relief after making the payment, I undertake to repay the same along with interest at the rate of 12%.

Solemnly affirmed on _____ at _____ and I hereby affirm that the above declaration are true to the best of my knowledge and information.

DEPONENT