MEGHALAYA BUILDING & OTHER CONSTRUCTION WORKERS WELFARE BOARD :: LOWER LACHUMIERE:: SHILLONG
Ph No.: 0364 2501224; Email : mbocwwb@ gmail.com

FORM NO. XLIII

(See Rule 287)

APPLICATION FOR MEDICAL BENEFIT

1. (a). Name of the Applicant: ____________________
   (b). Address of the Applicant: ____________________
   ____
   ____
2. (a) Date of Birth: ____________________ (b) Age: ________
3. Registration No. in the M.B.O.C.W.W.B.: ____________________
4. Date of the first Payment of the last Subscription: ____________________
5. Total amount remitted: _____________
6. Details regarding disease/surgery: ____________________
   ____
7. Disability if any, due to disease or surgery (yes/no):
8. **Period of treatment as inpatient in Government Hospitals**
   (a) Date of admission in the hospital: ____________________
   (b) Date of Discharge from the hospital: _________________
9. Details of medical benefits received, (if any before):
   ____
   ____

DECLARATION

I hereby declare that the above statements are true and correct to the best of my knowledge and belief

Place:
Date:

Signature of the Applicant

Documents to be attached along with this filled form:

1. **Medical Certificate of disability issued by Chief Medical Officer**
2. **Receipts/Bills from the Hospital concern during the Stay.**
3. **Challan/Receipt of the last Montly Subscription paid.**