DEPARTMENT OF FAMILY WELFARE

CLAIM FORM UNDER FAMILY PLANNING INDEMINTY SCHEME

DISTRICT .....

1. This form is required to be completed for lodging claim under Section - 1 of the Policy.
2. This form is issued without admission of liability and must be completed and returned to the Family Welfare Bureaux for processing of claim.
3. No claim can be admitted unless certified by the Chief Medical Officer and attested by the Deputy Director of MEdical and Rural Health Services and Family Welfare designated for this purpose at District Level by the State Government.

Claim No. .....
(To be allotted by Family Welfare Bureaux)

DATE	MONTH	YEAR

1. Details of the claimant :

Name in full : ..... Present Age : ..... Years : .....

Relationship with the Accceptor of Sterilization : .....

Residential Address : .....

.....

.....

Telephone No. ..... Cell No. .....

2. Details of the person undergone Sterilization Operation :

Name in full : ..... Age : ..... Years : .....

Son / Wife of ..... : .....

Name of the spouse : .....Age of the spouse ..... Years

Residential Address : .....

.....

Telephone No. ..... Cell No. .....

3. Permanent Business or Occupation : .....

4. Details of Dependent Children :

S. No.	Name	Age (Yrs.)	Sex (M / F)	Whether Unmarried	If unmarried, whether dependent
1					
2					
3					
4					
5					

5. (a) (1) Date and Place of First Operation : .....

(2) Date and Place of Second Operation : .....

(b) (1) Nature of 1st Sterilization Operation : .....

(1) Tubectomy .....

(a) Sterlization followed by MTP .....

(b) PS ..... as per the standards of Sterilization

(c) Interval TAT : ..... LMP Date : .....

(d) Caesarian Operation followed by Sterilization ..... (LSCS)

(2) Laparoscopy : .....

(3) Vasectomy : .....

(4) Any other surgery followed by Sterilization .....

(2) Nature of 2nd sterilizationOperation : .....

(1) Tubectomy .....

(a) Sterlization followed by MTP .....

(b) PS ..... as per the standards of Sterilization

(c) Interval TAT : ..... LMP Date : .....

(d) Caesarian Operation followed by Sterilization ..... (LSCS)

(2) Laparoscopy : .....

(3) Vasectomy : .....

(4) Any other surgery followed by Sterilization .....

6 (a) (1) Name, addresss and qualification of the doctor who conducted the first operation :

(2) Name, addresss and qualification of the doctor who conducted the second operation :

(b) (1) Name, addresss of the hospital where first operation was conducted :

(2) Name, addresss of the hospital where second operation was conducted :

(c) Incase of private hospital, please specify whether the hospital is accredited for Family Welfare Service :

Yes		No	

(d) Whether Surgeon is in an Empanelment List :

Yes		No	

If yes, Empamelment No. as per List : E. No. .....

6. (e) Nature of claim :

(i) Failure of Sterilization, not leading to Child Birth
(Claim to be sent after MTP with Tubectomy)

(ii) Failure of Sterilization, leading to Child Birth
(Claim to be sent after conducting second Operation)

(iii) Medical Complication due to Sterilization
(state exact nature of complication)

a. Date : .....

b. Details of Complication : .....

c. Doctor / Health facility : .....

(iv) Death following Sterilization :

a) Date of addmission : ..... Time : .....

b) Date of discharge : ..... Time : .....

c) Date of death : ..... Time : .....

7. Give details of any disease suffered by acceptor
prior to undergoing sterilization operation :

8. Are you insured elsewhere if so, please give datails :

a) Name of the Insurance Company and address : .....
.....

b) Sum Insured : .....

I hereby declare that the particulars are true to the best of my knowledge and warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false of untrue statement, suppression or concealment of fact, my rights to the compensation shall be absolutely forfeited.

I hereby claim a sum of Rs. ..... under the Family Planning Indemnity Scheme.

Name of Acceptor / Claimant : .....

Signature (in full) or Thumb Impression : .....

Date :

Place :

MEDICAL CERTIFICATE ISSUED BY CHIEF MEDICAL OFFICER (CMO) AND ATTESTED BY DEPUTY DIRECTOR (FAMILY WELFARE) (DD(FW) DESIGNATED FOR THIS PURPOSE AT DISTRICT LEVEL.

It is Certified that Smt. / Shri. .....

S/o, W/o ..... R/o .....

..... had undergone sterilization opertation

on ..... at ..... Hospital and the Sterilization

Operation conducted by Dr. ..... Qualifications .....

I / We have examined all the Medical Records and Documents and hereby conclude that the Sterilization Operation is the antecedent cause of :

(a) Failure of Sterilization not leading to Child Birth (_____)
(Attach documentary evidence)

(b) Failure of Sterilization leading to Child Birth (_____)
(Attach documentary evidence)

(c) Medical Complication (Please given the details as under)

i) Nature of Complication .....

ii) Period .....

III) Expenses incurred for treatment of complication Rs. _____
(Attach Original Bills / Receipts / Prescriptions)

(d) Cause of Death of the Sterilization Acceptor _____

a) Date of Admission : ..... Time : .....

b) Date of Discharge : ..... Time : .....

c) Date of Death : ..... Time : .....

I have further examined all the particulars stated in the Claim Form and are in Conformity with my findings and is eligible for a compensation of Rs. ..... due to .....
.....(Cause) Please pay Rs. ..... to the District RKS and Rs. ..... to the beneficiary.

Signature :

Name :

Telephone No. :

Desigantion :

Date : Seal :

Documents enclosed :

a) Attested copy of Sterilization Certificattion

b) Attested copy of Consent Form

c) .....

d) .....

CHECKLIST FOR STERILIZATION CLAIMS

CLAIMANT :

DISTRICT : STATE :

TYPE OF CLAIM :

DOCUMENTS FOR DEATH CLAIM : (For Office Use only)

S. No.	DOCUMENT	WHETHER ATTACHED				WHETHER ATTESTED			
1	Claim Form cum Medical Report	YES		NO		YES		NO	
2	Consent Form	YES		NO		YES		NO	
3	Death Certificate	YES		NO		YES		NO	
4	Sterilization Certificate	YES		NO		YES		NO	

DOCUMENTS FOR FAILURE CLAIM :

S.No.	DOCUMENT	WHETHER ATTACHED				WHETHER ATTESTED			
1	Claim Form cum Medical Report	YES		NO		YES		NO	
2	Consent Form	YES		NO		YES		NO	
3	Sterilization Certificate	YES		NO		YES		NO	
4	Proof of Failuire - Either of the below (Tick the document which is attached)								
	Urine Test Report	YES		NO		YES		NO	
	USG Report	YES		NO		YES		NO	
	Per Abdominal Examination	YES		NO		YES		NO	
	MTP Report	YES		NO		YES		NO	
	Semen Test Report (incase of Male Sterilization	YES		NO		YES		NO	

(Attested Birth Certificate to be attached)

DOCUMENTS FOR FAILURE CLAIM :

S. No.	DOCUMENT	WHETHER ATTACHED				WHETHER ATTESTED			
1	Claim Form cum Medical Report	YES		NO		YES		NO	
2	Consent Form	YES		NO		YES		NO	
3	Sterilization Certificate	YES		NO		YES		NO	
4	Original bills , receipts, and diagnostic reports	YES		NO		YES		NO	
5 .	Case Sheet confirming the treatment given	YES		NO		YES		NO	

Name :

Designation :

Signature :