



**THE KALYAN JANATA
SAHAKARI BANK LTD.**
दि कल्याण जनता सहकारी बँक लि.

MULTI STATE SCHEDULED BANK

Head office : "Kalyanam_astu", Adharwadi, Kalyan (West) 421301

Website : www.kalyanjanata.in

SHR - 14

FORM FOR FREE MEDICAL CHECK UP UNDER SHARE HOLDERS' WELFARE FUND SCHEME

Mr./Mrs./M/s. _____
SURNAME FIRST NAME MIDDLE NAME

Room & Floor No. _____ Name of Building _____

Road Name / Lane No. _____ Area / Locality _____ City _____

Pin Code Contact No. _____

Date :

To,
The Chief Executive Officer,
The Kalyan Janata Sahakari Bank Ltd.,
Kalyan (West)

Dear Sir/Madam,

I am member of the bank having Membership No. _____, I wish to apply for free medical check-up facility under Share Holders' Welfare Fund scheme at **Shree Hospital, Shree Ganesh Baug, Murbad Road, Kalyan (W) 421301. (Contact Nos. 0251-2200529 / 2209926)** as approved by bank

Age as on date : _____ years. (Only for Male Members)

Account No.

Branch : _____

(Signature of Member)

Enclosed :

(1) Copy of membership I-Card or Share Certificate/s

(2) Copy of Age Proof (Only for Male Members)

Required Criteria for Free Medical Check-up :

- (1) Member can apply for this assistance after completion of two years of membership.
- (2) Male member above 60 years can apply. (3) No age limit for female members.
- (4) Member can avail free Medical Check up facility once in two years i.e., period between two medical check-ups should be more than two years.
- (5) In case of joint shareholding, benefits are extended only to the member whose name appears 1st in the register of shareholders maintained by bank.
- (6) Minimum shareholding of ₹ 1000/- (7) Member should comply KYC requirements as per RBI guidelines.
- (8) Member should hold minimum deposit of ₹ 500/- or should have opted minimum loan facility of ₹ 1,00,000/-
(As on 31st March of immediate preceding financial year)

Traveling expenses to / from the hospital will not be paid by the bank.

Following Check-ups will be done :

- (1) Blood - C.B.C., H.B. (2) Blood Sugar (Random) (3) Urine (Routine) (4) E.C.G. (5) Examination by physician

In addition to above for female members : Medical Examination by Gynaecologist.

FOR BRANCH USE ONLY

Customer No. _____ KYC Complied : Yes No Branch : _____

Copy of documents received & signature verified by _____

Date

EMPLOYEE NO.	SIGNATURE

(Signature of Branch Official with Branch Stamp)

FOR HEAD OFFICE USE ONLY (SHARE DEPARTMENT)

Remarks : Letter for Free Medical Check-up Issued on :