

**FAMILY BENEFIT SCHEME**  
**INDIAN SOCIETY OF ANAESTHESIOLOGISTS**  
**Office: CARE EMERGENCY HOSPITAL**  
Near II Town Police Station,  
Main Road, KAKINADA - 533 001.

**CLAIM FORM**  
**FOR**  
**FRATERNITY CONTRIBUTION**

Name of Deceased Member Dr. \_\_\_\_\_  
Son /Daughter/Wife/Nominee of \_\_\_\_\_  
Name of Local Branch of ISA to which attached \_\_\_\_\_  
FBS Registration No. \_\_\_\_\_ Date & Time of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_ Relationship to deceased member \_\_\_\_\_  
Name and Address of Claimant with Phone Number : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Signature of Claimant*

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**CERTIFICATE**

This is to certify that Dr. \_\_\_\_\_ who has  
expired on \_\_\_\_\_ due to \_\_\_\_\_ is a member of the ISA and  
Family Benefit Scheme through \_\_\_\_\_ Local Branch. The Claimant's  
signature above is made in my presence and is attested by me.

Forwarded to Hon. Secretary Family Benefits Scheme Indian Society of  
Anesthesiologists.

Hon. Secretary.  
ISA \_\_\_\_\_ Branch,  
(Rubber Stamp of ISA branch compulsory)

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**DETAILS OF BANK ACCOUNT OF NOMINEE**

Name of Nominee (as in the bank account) \_\_\_\_\_ Account No. \_\_\_\_\_  
Name of Bank and Branch \_\_\_\_\_  
Address of the Bank : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of the Nominee :

I herewith attest the signature of the person above and the details of the account are correct.

\_\_\_\_\_  
Branch Manager.

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NOTE: This claim form duly filled up, signed and attested must be sent to the Hon.  
Secretary, Family Benefit Scheme of ISA along with the following enclosures through  
the local branch secretary without fail.

1. Copy of Death Certificate from appropriate authority (Municipal / Panchayath etc.,) duly  
notarized.
2. Medical Certificate from the Medical attendant regarding the illness and cause of death.
3. Membership certificate issued by the Family Benefit Scheme / ISA in Original.

