"Family Planning Indemnity Scheme" (FPIS)

Objective of the scheme:

Compensation for Death/Failure/Complication following sterilization operation.

Salient feature of the scheme/Eligibility Criteria:

Section	Coverage	Revised limits
I A	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital.	Rs. 4 lakhs
I B	Death following sterilization within 8 - 30 days from the date of discharge from the hospital.	Rs. 1 lakh
I C	Failure of sterilization.	Rs. 60,000/-
I D	Cost of treatment in hospital and upto 60 days arising out of complication following sterilization operation inclusive of complication during process of sterilization operation from the date of discharge.	Actual not exceeding Rs.50,000/-

Requirement of Documents to avail the Scheme:

a. Failure of Sterilization operation documents with original & one set of Xerox copy for payment.
b. Claim form.
c. Consent form cum Application form for sterilization operation.
d. New Sterilization Certificate (in original).
e. New case paper.
f. Admit paper.
g. Discharge card.
h. Old case paper.
i. Old Ligation certificate (in original).
j. Aadhar card & Election card of both husband & wife.
k. Birth certificate of both the child.
l. Bank details with 2 photo copies of beneficiary.

Prescribed form if any: Yes. Form enclosed.

Mode or procedure to avail the benefit of scheme:

The beneficiary reports to the respective health facility. The incharge of the health facility reports the case to the District Indemnity Scheme Committee which is headed by the Collector which are then verified and sent to the state office for payment.

Details of Office where the application to be submitted:

Office Medical Superintendent of District Hospitals, Sub District Hospitals and Health Officer of the respective CHC/PHC/UHC.

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Claim Form for Family Planning Indemnity Scheme

1. This form "Claim Form cum Medical Certificate" is required to be completed for lodging claim under Section-I of the scheme.
2. This form is issued without admission of liability and must be completed and returned to the District Health Society/State Health Society for processing of claim.
3. **No claim can be admitted unless certified by the convener of DISC (CMO or Equivalent) designated for this purpose at district level by the State Government.**

Claim no. : _____

PART A: Beneficiary/Claimant Information (To be Submitted by Claimant)

1. **Details of the Claimant:**

   Name in full: _____ Present Age: _____ Years

   Relationship with the beneficiary of Sterilization: _____

   Residential Address: _____

   _____ Telephone no. _____

2. **Details of the person undergone sterilization operation:**

   Name in Full: _____ Age: _____ Years

   Son /daughter of: _____

   Name of the Spouse: _____ Age of the Spouse: _____Years

   Address: _____

3. **Occupation/Business:** _____

4. **Details of Dependent children:**

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

5. **(a) Date of Sterilization Operation:**_____

   (b) Nature of Sterilization operation:

   (i) Interval Tubectomy: _____

   (ii) Vasectomy: _____

   (iii) MTP followed by sterilization: _____

(iv) Post Partum Sterilization (Caesarean/ Normal Delivery): _____

(v) Any other surgery followed by sterilization: _____

6. **(a) Name and address of the doctor who conducted the operation:**

_____

(b) Name and address of the hospital where operation was conducted:

_____

(c) Nature of claim:

1) Failure of sterilization :

2) Complication due to Sterilization (state exact nature of complication):

a. Date: _____

b. Details of Complication:_____

c. Doctor /Health facility: _____

3) Death attributable to sterilization:

a. Date of Admission: _____ Time:_____

b. Date of Discharge :_____ Time:_____

c. Date of Death:_____ Time:_____

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

_____

_____

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 right to the compensation shall be absolutely forfeited.

I hereby claim a sum of Rs._____/- under the scheme, which I agree in full settlement of my claim and shall have no further right whatsoever to claim under the scheme.

Date: _____ **Name of Client/Claimant: _____**

Place: _____ **Signature (in full) or thumb impression**

PART B: MEDICAL CERTIFICATE

(To be issued by CMO or Equivalent designated for this purpose at district level)

It is certified that Smt/Shri. _____

S/o/W/o: _____

R/o_____

had undergone _____(Specify which procedure was done) sterilization operation on_____ at _____ (hospital) and conducted by Dr._____Qualifications _____empanelled for _____procedure posted at _____

_____

Nature of Sterilization operation done:

(i) Interval Tubectomy: _____

(ii) Vasectomy: _____

(iii) MTP followed by Sterilization: _____

(iv) Post Partum Sterilization (Caesarean/ Normal Delivery): _____

(v) Any other surgery followed by Sterilization: _____

I have examined all the medical records and documents and hereby conclude that the sterilization operation is the antecedent cause of:

(a) Failure of Sterilization (Attach documentary evidence)

(b) Complication: (please give the details as under)

  (i) Nature of Complication:_____ _____

  (ii) Period: _____

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

(c) Death of Person (cause): _____

  a. Date of Admission: _____ Time: _____

  b. Date of Discharge:_____ Time: _____

  c. Date of Death: _____ Time: _____ **(Attach death certificate)**

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 beneficiary.

Documents Enclosed:

(a) Original Claim cum Medical certificate ( )

(b) Attested copy of sterilization certificate (If applicable) ( )

(c) Attested copy of consent form ( )

(d) _____ ( )

(e) _____ ( )

Date:_____ **Seal:**

Name_____

Designation_____

Tel/Mob. No. _____ **Signature _____**