Annexure B-1

Contributory Scheme for Post Retirement Medical Facilities for Expenses (Clause 6.1)

CLAIM FORM FOR PAYMENT OF OUTDOOR TREATMENT EXPENSES

Period of Claim: Half year ending 30th June_____ / 31st December_____

1. Name & grade of the retired executive/spouse :
2. PIS No. :
3. Registration No. of Medical Card :
4. Fixed Amount for Outdoor/Domiciliary treatment : Based on date of retirement (Rupees)
5. Amount Claimed (Rupees/Paise) :
6. Name of Bank and Branch with single-owned : Savings Bank Account Number where the amount Shall be credited AND Present Address at which Cheque is to be sent :

(To be certified by the retired executive)

i. The statements made in the claim are true to the best of my knowledge and belief
ii. I am a member of Contributory Scheme for Post Retirement Medical Facilities and my Medical Card is valid since _____
iii. I continue to fulfill the conditions of eligibility for availing the benefits under the scheme
iv. The Medical expenses were incurred for self/spouse
v. I fully understand that the Company may refuse/terminate my membership of the scheme at any time without any notice and without assigning any reason.
vi. Certified that myself and my spouse are not availing any medical facilities from or through the Central/State Govt./Public Sector Undertaking/Quasi Govt. Body or any Medical Insurance Company either in individual capacity or as dependent

Date :

Signature of the retired executive/spouse

_____

The claim has been scrutinized and recommended for payment of Rs.....

(Rupees_____) only

_____

Chief of Medical Service

(To be filled in by the Accounts Department)

Claim passed for payment of Rs. _____ Rupees (in words) _____

Accountant Sr. A.O/A.O. Date :

Annexure-B/2

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY THE RETIRED EXECUTIVE

Name & Code :

Registration of Medical card :

Present address at which the Cheque is to be sent: _____

1.	Name of the patient	:	
2.	Relationship with the Retired executive	:	
3.	Place at which patient fell ill	:	
4.	If treatment taken at place rather than place of residence, give reasons	:	
5.	Name of the doctor & hospital from where treatment taken	:	
6.	Qualification of the doctor	:	

Note: 1) Doctor's prescription and cash memos in original should be attached.
2) Receipts of amount claimed should be enclosed.
3) Separate claims should prepared for each patient and each spell of treatment.

(To be certified by the retired executive)

I hereby declare that :

i) The statements made in the claim are true to the best of my knowledge and belief.
ii) I am a member of Contributory Scheme for Post Retirement Medical Facilities and my Medical Card is valid since _____.
iii) I continue to fulfill the conditions of eligibility for availing the benefits under the scheme.
iv) The Medical expenses were incurred for self/spouse.
v) I fully understand that the Company may refuse/terminate my membership of the scheme at any time without any notice and without assigning any reasons.
vi) Myself and my spouse are not availing any medical facilities from or through the Central/State Govt/Public Sector Undertaking/Quasi Govt. Body either in individual capacity or as dependent.

Date:

(Signature of the retired executive/
living spouse in case of death of retired executive)

The claim has been scrutinized and recommended for payment of Rs._____ (Rupees _____ _____) only

Chief of Medical Services

(To be filled in by the Accounts Department)

Claim passed for payment of Rupees (in words) _____
(in figures)_____

Accountant Sr. A.O./A.O. Dated:

Annexure-B/3

(DETAILS OF THE AMOUNT CLAIMED)

			HOSPITALIZATION CASE	AMOUNT	
	Rs.	P.		Rs.	P.
1. CONSULTATION FEES Date Amount a) b) c) d) **TOTAL 1.**			5. ACCOMMODATION CHARGES FOR THE PERIOD FROM : TO : @Rs.....per day.		
2. INJECTION ADMINISTRATION FEES Date Amount a) b) c) d) **TOTAL 2.**			6. SURGICAL OPERATION OR CONFINEMENT CHARGES		
3. MEDICINES PURCHASED FROM MARKET Date Amount a) b) c) d) **TOTAL 3.**			1. COST OF MEDICINES		
A. TOTAL (1+2+3)			**C. TOTAL (5+6+7)**		
4. PATHOLOGICAL/OTHER TESTS Name of the test Amount a) b) c) d) **B. TOTAL 4.**			**TOTAL AMOUNT CLAIMED (A+B+C)**		

Date:

(Signature of the retired executive/
living spouse in case of death of retired executive)

DETAILS OF AMOUNT DISALLOWED

Reason	Amount
1.	
2.	
3.	