



A Maharatna Company

Annexure-B/1

Contributory Scheme for Post Retirement Medical Facilities for Executives (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: