COAL INDIA LIMITED, COAL BHAWAN, ACTION AREA- IV, NEW TOWN , RAJARHAT, KOL-700156.

Contributory Scheme for Post Retirement Medical Facilities for Non-Executives. Annexure B2

(See Clause 6.2)

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCLUDED BY THE RETIRED NON-EXECUTIVE

NAME & CODE No.- :_____

Registration of Medical Card :_____

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

_____.

1. Name of the Patient :_____
2. Relationship with the retired Non-executive :_____
3. Place of which Patient fell ill :_____
4. If the treatment taken place rather than the Place of residence, give reason :_____
5. Name of the Doctor & Hospital from where Treatment taken :_____
6. Qualification of the Doctor :_____

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

(TO BE CERTIFIED BY THE RETIRED NON-EXECUTIVE)

I hereby declare that :

i)The statement made in the claim are true to the best of my knowledge and belief.
ii)I, am member of Contributory Scheme for post 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 ret.Non-Executive / Living Spouse of the Death of Ret. Non. Executive.

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

Chief of Medical Services

(To be filled by the Accounts Department)
Claim passed for payment of Rupees (in Wards).....
(in Figures).....

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

Contributory Scheme for Post-Retirement Medical Facilities for Non-executives. ANNEX-B3

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY THE RET.NON-EXECUTIVE

(DETAILS OF THE AMOUNT CLAIMED)

			HOSPITALISATION CASE	AMOUNT	
	Rs	P		Rs.	P
1.CONSULTATION FEES Date Amount a) b) c) Total 1.			5.Accomodation charges for the period FROM: TO: Rs ..... per day		
2.INJECTION ADMINISTRATION FEES Date Amount a) b) c) Total 2.			6.SURGICAL OPERATION OR CONFINEMENT CHARGES.		
3.MEDICINES PURCHAS FROM MARKET Date Amount a) b) c) Total 3.			7.COST OF MEDICINES		
A. TOTAL(1+2+3)			B.TOTAL(5+6+7)		
4.PATH/OTHER TESTS Name of test Date a) b) c) d) B. Total 4.			TOTAL AMOUNT CLAIMED (A+B+C)		

Date:

Sign.of ret.non-exectv/Living
Spouse of death of ret.non-executive.

DETAILES OF AMOUNT DISALLOWED

REASONS:

1.

2.

3.

4.