Date of Release: 22/02/2023

CLAIM FOR REIMBURSEMENT OF DOMICILIARY TREATMENT UNDER POST RETIREMENT MEDICAL BENEFIT SCHEME

1.	Name of the ex-employee	:	
2.	Employee Code No.	:	
3.	Date of Retirement	:	

I certify that I have incurred a sum of Rs.______________for medical expenses for myself and my Spouse* Mr./Mrs.__________________________ for the period from________to____________.

Kindly reimburse the amount at my Bank A/c as per details below

(Please fill if change from previous year and enclosed one cancelled cheque).

6.	Bank A/c No.	:	
7.	Name of Bank	:	
8.	Branch Name & Address	:	
9.	IFSC No.	:	

Signature	
Name of the Claimant	
Address	
E-mail	
Phone No./ Mobile No.	

* Strike off if it is not applicable.
In case of death of Ex-Employee/Spouse, kindly mention the name of the deceased ______________ ______________and date of death on ________________.

Note: The claims made by members for reimbursement of Domiciliary Treatment will be processed on self-certification basis. The periodicity of the claim will be twice in a financial year on six months' period, i.e., first claim is to be made in the month of September and second claim is to be made in the month of March in respect of each financial year. Such self- certification should be submitted by the members within 1st to 15th day of September and 1st to 15th day of March in respect of each financial year.