THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

APPLICATION FOR MEMBERSHIP UNDER OPRIMSE- SCCL **ANNEXURE-I**

(To be submitted in Duplicate) **Date:**_____

To
The General Manager (Personnel)/EE&RC,
The Singareni Collieries Company Ltd.,
Kothagudem.

Sub: Contributory Post Retirement Medicare Scheme for Executives of SCCL - Reg.
Ref: Circular No. CRP/PER/C/06/1752, dated 04.07.2013.

Affix photograph of self duly attested by any executive of SCCL with Office Stamp	Affix photograph of spouse duly attested by any executive of SCCL with Office Stamp	Affix photograph of Nominee duly attested by any executive of SCCL with Office Stamp
Photograph of the Retired Executive	Photograph of the Spouse	Photograph of the Nominee

Dear Sir,

I hereby express my willingness to join the Contributory Post Retirement Medicare Scheme for Executives of SCCL and request that Medical Identity Card may be issued on my name. I am enclosing herewith a Demand Draft obtained from *_____branch of *_____Bank in favour of SCCL payable at Kothagudem for Rs.*_____ towards membership amount and necessary particulars are furnished below:

Sl.No.	Description	Details
01	Full Name of the Retired Executive with Surname(for writing on the Medical Card)	
02	E.C. No.	
03	Blood Group of Ex-executive	
04	Date of cessation of the Company's Service (Tick the relevant reason)	Indicate Date:
05	Reason for cessation(Tick applicable)	Superannuation / VRS / Death / MBU (in case of death of ex-executive indicate date of death)
06	Designation & Grade at the time of Cessation of Service	
07	Mine/Dept. & Area from where Retired/VRS/Death/MBU	
08	Name of the Spouse with surname	
09	Date of Birth of spouse	
10	Blood Group of Spouse	
11	Membership Amount paid Rs.	
12	No. & Date of Demand Draft Name of Issuing Bank with Branch name	*
13	Name of the Issuing Bank & Branch	*
14	Full Permanent Postal Address with Telephone and/or Mobile No.	
15	Present Postal Address with Telephone and/or Mobile No.	

Sl.No.	Description	Details
16	**Savings Bank A/c No. for payment of Half yearly payment. (SBH Acccount only) Name of the Bank with Branch Name/City IFSC Code of the Bank (enclose a copy of Bank Passbook)**	
17	Name of the Nominee with relationship (compulsory)	
18	Address of the Nominee with Telephone and/or Mobile No.	
19	Enclose 2 additional Passport size Photographs each of Self, Spouse and Nominee without attestation for affixing on Medical Card	2 Passport size Photographs of self, 2 Passport size Photographs of spouse and 2 Passport size Photographs of Nominee are enclosed without attestation for affixing on Medical Card in addition to the photographs affixed and attested by any executive of SCCL on this form

DECLARATION

1. 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 (applicable for executives who have retired prior to 01.01.07). I will claim medical reimbursement either from SCCL or Insurance Company only but not both.
2. I clearly read and understood the Contributory Post Retirement Medicare Scheme for Executives and I abide by the rules furnished in the said Scheme as modified by SCCL from time to time.
3. I will submit my Life Certificate for every year ending December by 31st January of subsequent year to EE Cell.
4. I will submit Form-B-1 to CMO, MH,KGM on 30th June / 31st December every year for half yearly payment.
5. If it is found that there is misuse of the benefits under the Scheme by me / spouse /Nominee, we may be debarred from the benefits under the scheme in accordance with Clause 7.2 of the Scheme.

(Name and signature of the retired executive) (Name and signature of the spouse) (Name and Signature of Nominee)

Place:_____ Date:_____

NB: (i) Application is to be submitted in DUPLICATE with photographs affixed & attested. One copy of Medical Card Progorma with photographs(without attestation).
(ii) Attestation of only TWO photographs each of self, spouse and Nominee affixed on this application should be done by any executive of the Company with Office Seal.

FOR OFFICE USE ONLY

Received Rs._____Vide Draft No. _____ dated _____ Of _____Branch of _____Bank. Medical Identity Card No._____has been issued to the above ex-executive on _____under CPRMSE.

Checked and found in order.

Signature of Receiving Section Clerk **Signature of Section Officer**

Head of Executive Establishment Cell
(Office Stamp)

*Strike-off if not applicable.

THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

Regd. Office: PO: Kothagudem Collieries-507101, Khammam Dist. (AP)

Medical Card

Office Copy

Contributory Scheme for Post Retirement Facilities for Executives

Registration No: CPRMSE -

Photograph of the Retired Executive	Photograph of the spouse	Photograph of the Nominee
Photograph of Retired Executive	Photograph of the spouse	Photograph of the nominee

Sl. No.	Description	Details
1.	Name of the Retired Executive	
2.	Employee Code No.	
3.	Date of Birth	
4.	Blood Group	
5.	Name of spouse & Date of Birth	
6.	Blood Group of Spouse	
7.	Date of retirement / BMU/Death	
8.	Design. at the time of Retirement	
9.	Scale of pay and Basic pay as on the date of retirement/BMU/ Death	
10.	Mine/Department & Area from where Retired/BMU/Died	

P.T.O

11.	No. and date of D.D. remitted	
12.	Name of the Issuing Bank	
13.	Permanent Address with Pin Code, Telephone and/or Mobile No.	
14.	Present Address with Pin Code, Telephone and/or Mobile No.	
15.	Name of the Nominee, if any with Address & Mobile No.	

Declaration

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 (applicable for executives who have retired prior to 01.01.07)

(Signature of Retired Executive) (Signature of the Spouse) (Signature of the nominee)

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(For Office Use)

Received Rs._____ Vide Draft No._____ dated _____

Of _____ Branch of _____Bank.

Date: _____

Signature of receiving Staff **Signature of receiving Officer**

Validity Period of the Card - From _____ To _____

Date of Issue:_____

Signature of Issuing Authority with seal

Note: Please preserve this Card Carefully. Duplicate card will not be issued.

OPTION FORM FOR AVAILING THE FACILITY OF MEDICARE IN SCCL COMPANY HOSPITALS.
(As Per Clause 3.2.3 of CPRMSE)

TO,
THE CHIEF MEDICAL OFFICER,
SCCL – KOTHAGUDEM.

(Through ACMO / DY.CMO – AH - _____)

I the undersigned a member of CPRMSE would like to receive medicare from Company hospitals at **KGM/RG/SRP/RKP / BPA** (Strike out other than the opted Hospital). **I am aware that I am not entitled to receive the amount payable under 3.2.2.** of the Scheme and also aware that for OP & IP treatment obtained at Company's Hospitals a notional rate of **40%** treatment cost will be charged to my account under the Scheme.

The option exercised by me is final and I will not submit any request in future to revoke the same during my life time.

In view of the above, it is requested to extend the facility to receive medicare to me & my spouse at _____..

Thanking you,

Yours faithfully,

( )

Designation :- Ex –
E.C.No. :-
Medical Card No.:-

Signature of Spouse of Ex-Employee.

Encl: Copy of Medical Card issued to me is enclosed

Date :
Place :

OPTION FORM FOR REIMBURSEMENT OF OUT-PATIENT DOMICILARY EXPENDITURE
(As Per Clause 3.2.2 of CPRMSE)

To

The General Manager (Per),
Welfare & CSR

I the undersigned have enrolled as a member of CPRMSE and would like to receive reimbursement of out-patient/domiciliary treatment expenditure from Company every year in accordance with clause 3.2.2 of CPRMSE. I am aware that I am not entitled to avail Medicare in any of the Company Hospitals/Dispensaries as per clause 3.2.3 of CPRMSE.

The option exercised by me is final and I will not submit any request in future to revoke the same.

Thanking You,

Yours Faithfully,

( )

Designation : Ex.

E.Co. No. :

Medical Card No. :

Sign. Of Spouse of Ex. Employee

Encl: Copy of Medical Card issued to me is enclosed.

Date :

Place: