THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

Annexure-B3

(DETAILS OF THE AMOUNT CLAIMED)

	AMOUNT		HOSPITALIZATION CASE	AMOUNT	
1.CONSULTATION FEES Date: Amount: a) b) c) d) Total.1			**5. ACCOMMODATION CHARGES FOR THE PERIOD** FROM: TO: @ Rs. _____per day.		
2.INJECTION ADMINISTRATIO 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**			**7. COST OF MEDICINE:**		
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 AMOUNTS DISALLOWED

Reason: **Amount:**

1)
2)
3)
4)

Chief Medical Officer

Dated:_____ **Staff/Accountant** **DGM(F&A)/FM/Dy.FM** **G.M.(F&A)**

Annexure-B2

Contributory Scheme for Post Retirement Medical Facilities for Executives (Clause 6.2)

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

Name & Employee 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 in ORIGINAL
3) Separate claims should be 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.
vi) All the relevant Bills in Original are enclosed with this claim form.

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 Medical Officer

(To be filled in by the Accounts Department)

Claim passed for payment of Rupees (in words) _____

(in figures)_____

Dated:_____ **Staff/Accountant** **DGM(F&A)/FM/Dy.FM** **G.M.(F&A)**