

Proforma to be submitted by the Ex-employees/spouse for membership in CPRMS for Non-Executives.

To
The Head of the Mine/Dept.
_____ (Mine/Department)
_____ Area.

Sir,

Sub:- Application for membership in Contributory Post Retirement Medicare Scheme (CPRMS) for Non-Executives-Modified – Reg.

Ref:- Circular No. _____ dt. _____

Reference above, I, _____ /spouse of (Name of the ex-employee), _____ (Employee Code No), _____ (designation), _____ (Place of work/Area), retired on superannuation/VRS/declared medical unfit/Medical Invalidation/resignation at the age of 57 years or above (Tick whichever is applicable) on _____ (copy of termination letter indicating the mode of exit from service) wish to join the Contributory Post Retirement Scheme for Non-Executive cadre employees (Modified) of SCCL.

- i. I/My spouse had exited in X wage agreement but had not applied earlier /applied as single beneficiary and wish to pay the difference amount totaling Rs.40,000/- (delete whichever is not applicable)
- ii. I/My spouse had exited prior to X wage agreement and enrolling a fresh/wish to pay the difference amount totaling Rs.40,000/- (delete whichever is not applicable)

I request you to kindly accept my application for the above Scheme and arrange to indicate the membership amount to be paid by me which I am ready to pay.

Yours faithfully,

Address for correspondence :

Signature/LTI of the Ex-employee/Spouse

Name:

E.C No.

Encl: as above

Designation:

Place of work:

Date:

Certification by the Head of the Mine/Department

It is certified that the termination letter/notice of termination submitted by the ex-employee/spouse has been verified with the available company records and he/she is eligible to join the CPRM Scheme for Non-Executives (Modified). For this purpose an amount of Rs. _____ was recovered from his/her salary in months from _____ to _____ / salary arrears of Rs. _____ (details of X wage arrears) in the month of _____ towards membership fee in the Scheme. As such, he/she has to pay balance amount of Rs. _____ by way of Demand Draft drawn in favour of _____ to fulfill the condition of total contribution of Rs.40,000/-

Signature of Welfare Officer/

POA of the Mine/Dept.

Date:

Signature of Head of Mine/Department

Date:

Proforma to be submitted by the Ex-employees/spouse or Member of the Scheme for membership of his/her Divyang Child in CPRMS for Non-Executives(Modified).

To
The Head of the Mine/Dept.
_____ (Mine/Department)
_____ Area.

Sir,

Sub:- Application for membership for my **Divyang Child** in Contributory Post Retirement Medicare Scheme (CPRMS) for Non-Executives(Modified) – Reg.

Ref:- Circular No. _____ dt. _____

Reference above, I, _____ /spouse of (Name of the ex-employee), _____ (Employee Code No), _____ (designation), _____ (Place of work/Area), retired on superannuation/VRS/declared medical unfit /resignation at the age of 57 years or above (Tick whichever is applicable) on _____ (copy of termination letter indicating the mode of exit from service wish to my Divyang Children namely _____ in the Contributory Post Retirement Scheme for Non-Executive cadre employees of SCCL (CPRMS-NE[Modified])).

I request you to kindly accept my application for the above Scheme and arrange to indicate the membership amount to be paid by me which I am ready to pay.

Yours faithfully,

Address for correspondence :

Signature/LTI of the Ex-employee/Spouse

Name:

E.C No.

Designation:

Place of work:

Encl: as above

Date:

Certification by the Head of the Mine/Department

It is certified that the termination letter/notice of termination submitted by the ex-employee/spouse has been verified with the available company records and he/she is eligible to join the CPRM Scheme for Non-Executives(modified). For this purpose he/she has to pay an amount of Rs. _____ by way of Demand Draft drawn in favour of _____ in the month of _____ towards membership fee in the Scheme for his/her Divyang Child..

Signature of Welfare Officer/

POA of the Mine/Dept.

Date:

Signature of Head of Mine/Department

Date:



THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

I.R.Wing, Corporate Personnel Department

Annexure- I

APPLICATION FOR MEMBERSHIP UNDER CPRMS FOR NON-EXECUTIVES (Modified)

(To be submitted in Triplicate)

Date: _____

To
The Head of Mine/Dept.
The Singareni Collieries Company Ltd.,
_____ (Mine/Dept).
_____ (Area/Corporate)

*Affix photograph
of self duly attested
by the Head of
Mine / Department
with Office Stamp

*Affix photograph
of spouse duly
attested by the
Head of Mine/
Department with
Office Stamp

*Affix photograph
of nominee duly
attested by the
Head of Mine /
Department with
Office Stamp

Sir,

Sub:- Contributory Post Retirement Medicare Scheme for Non-Executives(Modified) – Reg.
Ref:- Circular No. _____

I hereby express my willingness to join the Contributory Retirement Medicare Scheme for Non-Executives(Modified) of SCCL and request that Medical Identity Card for this purpose 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. _____ / an amount of Rs. _____ was deducted from my salary / salary arrears in _____ (month(s) & year) [delete whichever is not applicable] towards membership amount and necessary particulars are furnished below:

1. Name of the Retired Non- Executive with Employee Code. :
2. Date of Birth :
3. Date of Appointment :
4. Blood Group :
5. Date of Cessation of Service of the Company & Reason :
(Copy of termination letter/death certificate to be enclosed)
6. Designation at the time of Retirement/Death/BMU/Medical Invalidation/Resignation at the age of 57 years or above :
7. Scale of pay and basic pay as on the date of retirement/Death/BMU/Medical Invalidation/Resignation :
8. Mine/Establishment/Unit from where exited :
9. Name of spouse with Date of Birth and whether employed (details) :
10. Blood Group of Spouse :
11. Amount, number and date of Demand Draft remitted & Name of the Issuing Bank and Branch(to enclose original D.D.) / Details of amount recovered from the salary/salary arrears :
12. Name of Bank and Branch with single-owned Savings Bank Account Number where the amount reimbursed shall be credited along with IFSC Code.(copy to be enclosed)
13. Permanent Postal Address with Telephone & Mobile No. :
14. Present Postal address with Telephone & Mobile No. :
15. Name of the nominee with relationship, if any. :
16. Address of the nominee and Telephone & Mobile No. :
17. Enclosed **2 additional Passport size photographs each of Self, Spouse and Nominee without attestation** for affixing on Medical Identity Card to be issued. :
18. To enclose existing Medical Card, if any:

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 dependant.
2. 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.
3. Certified that I have surrendered the Medical Card issued to me in accordance with Circular No.CRP/PER/WEL/MA/5076, dtd.12.03.2009 and Circular No.CRP/PER/IR/I/252/234, dtd.10.02.2011 and CRP/PER/IR/I/252/307 dt.09.02.2012.
4. I and my spouse opt to avail (i) indoor medical facilities in the company or (ii) indoor treatment from empanelled hospitals (to indicate the option ___) and the option exercised by me is final.
5. If it is identified that I have paid less than the membership amount, I will be eligible to avail the benefits only after paying the difference amount.
6. I am aware that for the same treatment benefit shall not be payable from any other source.

(Name and signature of the Ex non-executive)

(Name and signature of the spouse)

(Name and signature of Nominee)

Place: _____

Date: _____



THE SINGARENI COLLIERIES COMPANY LIMITED
(A Government Company)
I.R.Wing, Corporate Personnel Department

CERTIFICATE

Certified that the above information have been verified from the Office records and found to be correct. The photograph of the Ex-employee has also been certified.

Signature of Head of Mine / Department with Office Stamp

Place:

Date :

NB: (i) **Application is to be submitted in TRIPLICATE** (No need to submit Medical ID Card proforma)

(ii) * Attestation of only TWO photographs each of self, spouse and Nominee affixed on this application should be done by Head of Mine / Department with Office Seal.

For Office Use only

Membership amount required to be paid as per CPRMS-NE(Modified) _____

Received Rs. _____ vide Draft No. _____ dated _____ of _____ Branch of _____ Bank. Medical Identity Card No. _____ has been issued to the above Ex-Non-Executive on _____ under CPRMS for Non-Executives.

Date: _____

Section Clerk

Signature of receiving Officer with Stamp

Head of the Mine/Department



THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

I.R.Wing, Corporate Personnel Department

Annexure- II

APPLICATION FOR MEMBERSHIP UNDER CPRMS OF NON-EXECUTIVES (Modified) FOR DIVYANG CHILD
(To be submitted in Triplicate)

Date: _____

To
The Head of Mine/Dept.
The Singareni Collieries Company Ltd.,
_____ (Mine/Dept).
_____ (Area/Corporate)

*Affix photograph
of ex-employee/
spouse duly
attested by the
Head of Mine /
Department with
Office Stamp

*Affix photograph
of Divyang
Child/(Children)
duly attested by
the Head of Mine/
Department with
Office Stamp

*Affix photograph
of nominee duly
attested by the
Head of Mine /
Department with
Office Stamp

Sir,

Sub:- Contributory Post Retirement Medicare Scheme for Non-Executives(Modified)- Enrolment of name
of **Divyang Child** for availing the benefits under the scheme - Reg.

Ref:- Circular No. _____

I hereby express my willingness to join my Divyang Child namely _____ in the Contributory Retirement Medicare Scheme for Non-Executives of SCCL and request that Medical Identity Card for this purpose 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:

1. Name of the Retired Non- Executive/ with Employee Code/ Spouse (Member of the Scheme) :
2. Date of Birth :
3. Date of Appointment :
4. Blood Group :
5. Date of Cessation of Service of the Company & Reason (Copy of termination letter/death certificate to be enclosed) :
6. Designation at the time of Retirement/Death/Board Medical Unfit/Resignation :
7. Scale of pay and basic pay as on the date of retirement/Death/BMU :
8. Mine/Establishment/Unit from where retired :
9. Name of Divyang Child with Date of Birth and whether employed (details) :
10. Blood Group of Divyang Child :
11. Amount, number and date of Demand Draft remitted & Name of the Issuing Bank and Branch(to enclose original D.D.) :
12. Name of Bank and Branch with single-owned Savings Bank Account Number where the amount reimbursed shall be credited along with IFSC Code.(copy to be enclosed) :
13. Permanent Postal Address with Telephone & Mobile No. :
14. Present Postal address with Telephone & Mobile No. :
15. Name of the nominee with relationship, if any. :
16. Address of the nominee and Telephone & Mobile No. :
17. Enclosed **2 additional Passport size photographs each of Self/ Spouse, Divyang Child and Nominee without attestation** for affixing on Medical Identity Card to be issued. :
18. To enclose existing Medical Card, if any: :
19. Details of SADAREM Certificate certifying regarding the % of disability of the Divyang Child :

DECLARATION

1. Certified that Divyang child/children is/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 dependant.
2. If it is found that there is misuse of the benefits under the Scheme by me /Spouse / Divyang Child / Nominee we may be debarred from the benefits under the scheme in accordance with Clause 7.2 of the Scheme.
3. I opt to avail indoor treatment from empanelled hospitals (to indicate the option ___) for my Divyang Child and the option exercised by me is final.
4. I also certify that my Divyang child is fully financially dependent on me

P.T.O



THE SINGARENI COLLIERIES COMPANY LIMITED
 (A Government Company)
I.R.Wing, Corporate Personnel Department

5. I am aware that for the same treatment benefit shall not be payable from any other source.

(Name and signature of the retired, non-executive/Spouse (member of Scheme)
 Place: _____

(Name and signature/thumb impression of the Divyang Child(children))

(Name and signature of Nominee)

Date: _____

(P.T.O)

CERTIFICATE

Certified that the above information have been verified from the Office records and found to be correct. The photograph of the Ex-employee has also been certified.

Signature of Head of Mine / Department with Office Stamp

Place:
 Date :

- NB: (i) **Application is to be submitted in TRIPLICATE** (No need to submit Medical ID Card proforma)
 (ii) * Attestation of only TWO photographs each of self/spouse, Divyang Child/(children) and Nominee affixed on this application should be done by Head of Mine / Department with Office Seal.

For Office Use only

Membership amount required to be paid as per CPRMS-NE (Modified) _____

Received Rs. _____ vide Draft No. _____ dated _____ of _____ Branch of _____ Bank. Medical Identity Card No. _____ has been issued to the above Ex-Non-Executive on _____ under CPRMS for Non-Executives.

Date: _____

Section Clerk

Signature of receiving Officer with Stamp

Head of the Mine/Department



THE SINGARENI COLLIERIES COMPANY LIMITED

(A Government Company)

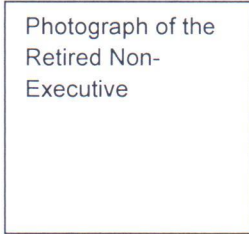
I.R.Wing, Corporate Personnel Department

Medical Card

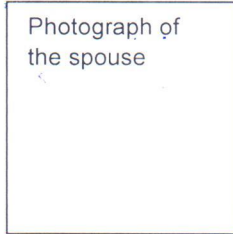
Annexure-A

Contributory Scheme for Post Retirement Medical Facilities for Non-Executives(Modified)

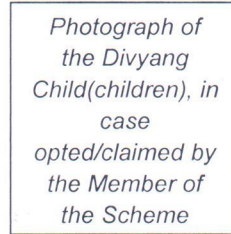
Registration No.: _____



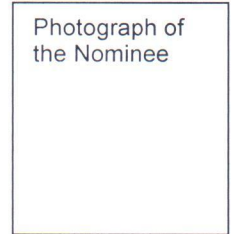
Photograph of the retired Non-Executive



Photograph of the Spouse



Photograph of the nominee, if any.



1. Name of the Retired Non-Executive with Employee No. :
2. Date of Birth :
3. Date of Appointment :
4. Blood Group :
5. Date of Cessation of Service of the Company & Reason :
6. Designation at the time of Retirement/Death/Board Medical Unfit :
7. Scale of pay and basic pay as on the date of retirement/Death/BMU/Medical Invalidation/Resignation at the age of 57 years or above. :
8. Mine/Establishment/Unit from where retired :
9. Name of spouse with Date of Birth and whether employed (details) :
10. Blood Group of Spouse :
11. Name of Bank and Branch with single-owned Savings Bank Account Number where the amount reimbursed shall be credited along with IFSC Code. :
12. Permanent Address with Telephone & Mobile No. :
13. Present address with Telephone & Mobile No. :
14. Name of the nominee with relationship, if any. :
15. Address of the nominee and Mobile No. :

DECLARATION

Certified that the above information is true to the best of my knowledge and 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 dependant.

(Name and signature of the Ex non-executive cadre employee)

(Name and signature of the spouse)

(Name and signature of Nominee)

Place: _____

Date: _____

For Office Use only

Received Rs. _____ vide Demand Draft No. _____ dated _____ of _____ Branch of _____ Bank. Medical Identity Card No. _____ has been issued to the above Ex-Non-Executive cadre employee on _____ under CPRMS for Non-Executives (Modified).
Date: _____

Signature of receiving Officer with Stamp

Signature of receiving Staff

Validity Period of the Card from : _____

Date of issue: _____

Signature of Issuing Authority with Seal

*IMPORTANT NOTE TO THE MEMBER: LIFE CERTIFICATE TO BE SUBMITTED IN DECEMBER EVERY YEAR POSITIVELY.

NOTE: PLEASE PRESERVE THIS CARD CAREFULLY. DUPLICATE WILL NOT BE ISSUED.





THE SINGARENI COLLIERIES COMPANY LIMITED
(A Government Company)
I.R.Wing, Corporate Personnel Department

Annexure-B1

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

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

Name & Employee Code : _____

Registration of Medical card : _____

Name of Bank and Branch with single-owned Savings Bank Account Number where the amount reimbursed shall be credited along with IFSC Code: _____

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

1	Name of the Patient	
2	Relationship with the retired Non-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.
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 :

- The statements made in the claim are true to the best of my knowledge and belief.
- I am a member of Contributory Scheme for Post Retirement Medical Facilities and my Medical Card is valid since _____.
- I continue to fulfill the conditions of eligibility for availing the benefits under the scheme.
- The Medical expenses were incurred for self/spouse.
- 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.
- 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 retired Non-executive/
living spouse in case of death of retired non-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) _____

Staff/Accountant

DGM(F&A)/FM/Dy.FM

GM(F&A)

Dated: _____



THE SINGARENI COLLIERIES COMPANY LIMITED
(A Government Company)
I.R.Wing, Corporate Personnel Department

Annexure-B2

Contributory Scheme for Post Retirement Medical Facilities for Non-Executives (Clause 6.2)
(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 ADMINISTRATION 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 Non-executive/ living spouse in case of death of retired Non-executive)			
<u>DETAILS OF AMOUNTS DISALLOWED</u>			
<u>Reason:</u>		<u>Amount:</u>	
1)			
2)			
3)			
4)			

Date: _____

Staff/Accountant

G.M(F&A) / DGM(F&A)/FM/Dy.FM





THE SINGARENI COLLIERIES COMPANY LIMITED
(A Government Company)

LIFE CERTIFICATE

To be submitted by CPRMS – NE member and spouse
To whom it may concern

This is to certify that 1) Shri/Smt/Ms _____ (member)
son/wife/daughter of Shri _____ and 2) Smt/Shri
_____ (spouse of member) residing
at _____ are known to me.

1) Shri/Smt/Ms _____ (member) and 2) Smt/Shri _____
_____ (spouse of member) is/are alive at the time of issuing this
certificate. This certificate is issued for revalidation of Medical Card issued under
Contributory Post Retirement Medicare Scheme for Non-Executives (CPRMS-NE).

The signature of Shri/Smt/Ms. _____ (Member) and
Smt/Shri _____ (Spouse of member) is attested hereunder.

Signature of Shri/Smt/Ms _____ (member)

Signature of Smt/Shri _____ (Spouse of member)

Signature Attested

Name of the person attesting with designation: _____

Signature of Registered Medical Practitioner with Reg. No. OR
Gazetted Officer of Central/State Govt. OR
The Branch Manager of the Bank where the retired Non-Executive/spouse is holding S.B. A/C OR
Head of the Mine/Dept. where the Ex-Employee last worked
Area Personnel Dept. Head/ Incharge AEPATB Cell of the concerned Area
With Seal /Stamp

Note: CPRMS-NE member (ex-employee/spouse) drawing pension should enclose copy of
latest digital Life Certificate obtained through Jeevan Pramaan portal.

Date:

Life certificate for the year ending: 12/ _____ (indicate year)

Registration No. of Medical Card: CPRMS-NE _____ E.C.No. _____
