A Government Company

LIFE CERTIFICATE

TO WHOM IT MAY CONCERN

This is to certify that Sri/Smt. _____ Son /Daughter of _____ and Sri/Smt. _____ Husband / Wife of _____ residing at _____ are / is known to me and alive at the time of issuing this certificate. This certificate is issued for release of payment for out-door/ domiciliary treatment under Contributory Post Retirement Medicare Scheme of Executives of SCCL.

The Signature/Signatures of the above mentioned person is / persons are attested hereunder.

Signature of Retired executive Sri/Smt._____

Signature of Spouse of retired Executive Sri/Smt._____

The above Signature is/Signatures are Attested

(Signature of Attesting Authority:)

(Name of the attesting authority & Seal/Stamp:)

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 Executive/spouse is holding S.B. A/C OR Any Officer of the company

With Seal /Stamp

Date: _____

Registration No. of Medical Card : CPRMSE/_____

Note: 1. Please note that in case of couple membership, signature of the executive and his spouse is mandatory.

2. This Certificate shall be sent to GM(Personnel)/EE&RC, Head Office, SCCL, Kothagudem-507101, Khammam Dist. (AP)

A Government Company

Annexure B1

Contributory Scheme for Post Retirement Medical Facilities for Executives Clause 6.1)

CLAIM FORM FOR PAYMENT OF OUTDOOR TREATMENT EXPENSES

(To be submitted to CMO, Main Hospital, Kothagudem-507101)

Period of Claim: Half year ending 30th June, 2014 / 31st December, 2013

Sl.No.	Description of details to be furnished	Details to be furnished
01	Name of the Retired Executive	
02	Employee Code No.	
03	Name of the Spouse	
04	Regn. No. of Medical Card	
05	Date of issue of Medical Card	
06	Amount Claimed towards Outdoor/domiciliary treatment	Rs.
07	Name of Bank and Branch with single owned SB Account Number where the amount shall be credited (Copy of Pass Book to be enclosed)	
08	Branch Code and IFSC code	
09	Present Address and contact Number of the claimant	

(To be certified by the retired executive)

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. 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 reason.
vi. 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 .

Date : _____

Signature of the retired executive/Spouse

(**To be filled in by the Medical Department)**

The claim has been scrutinized and recommended for payment of Rs. _____Rupees_____) only.

Chief Medical Officer

(To be filled in by the Corporate Accounts Department)

Claim passed for payment of Rs. _____ Rupees (in words) _____

Date :_____ Accountant AO/Sr. A.O/Dy.FM/FM