Annexure-A

MTNL RETIRED EMPLOYEES CONTRIBUTORY GROUP HEALTH INSURANCE SCHEME
APPLICATION FOR REGISTRATION & CLAIMS
(Tick mark whichever is applicable)

GM (Admn) HQ.
MTN L Delhi/Mumbai
Sir,

1. I am retired employee/dependent spouse of retd. employee of MTNL and would like to join the Company's Retired Employees Contributory Group Health Insurance Scheme.
2. I request that medical coverage be extended to self and/or spouse as named below:

Sl No.	Name of beneficiaries	Relation	Date of Birth	Affix Pasport Size Photograph	Affix Pasport Size Photograph
		Self		Self	Spouse
		Spouse			

Note: Please enclose two passport size photographs of each member specified in above.

1. Reimbursement of Indoor bills submitted from time to time may please be deposited in my bank account No. _____ with _____ Bank, New Delhi as admitted / through cheque drawn in my name
2. I undertake to notify to the company any change in the above particulars as soon as it occurs.
3. In understand that the company reserves the right to refuse the membership to any retire or terminate the same at any time, by giving one month's notice and specifying the reason thereof. Company's decision in this behalf shall be final.
4. I undertake to abide by the rules of this Scheme, as amended from time to time.

Yours faithfully,
Signature

Dated .....

Phone No. Res: _____ Mobile (1) _____ (2) _____

Name: _____

P.C. No.: _____ PPNo. _____ Staff No. _____

Date of Retirement _____ / Date of Expiry _____

Designation: _____ Scale of Pay _____ Basic Pay _____

Address for _____

Correspondence _____

_____

Signature of
Medical Inspector (HQ)

Date and Time

Signature of the
applicant _____

Dated _____

ANNEXURE-F

MTNL RETIRED EMPLOYEES CONTRIBUTORY GROUP HEALTH INSURANCE SCHEME

CERTIFICATION/DECLARATION

(Tick mark whichever is applicable)

1. Certified that I am not availing any other medical cover in consequent of employment of my spouse or any type of medical facility or allowance from any other source or CGHS facility.

2. Certified that my spouse is not employed.

3. Certified that my spouse, Mr/Mrs _____ is employed with/retired from _____ and availing medical facility/medical allowance from his/her employer. (A certificate of his/her employer to that effect is enclosed).

Date : _____

Place : _____

Signature :

Name : _____

Address : _____

_____

_____

Phone No. : _____

Mobile No. : _____