PENSIONER'S/GOVERNEMNT SERVANT'S LETTER OF AUTHORITY AND UNDERTAKING FOR OPENING PENSION SB ACCOUNT IN P.O FOR CREDITING PENSION

To,_______________

____

1. I hereby authorize the Postmaster/Sub-Postmaster to receive my monthly pension on my behalf and credit the same to my Savings Bank Account (Pension) on the last working day of every month as per particulars given below:-
   i. Name in full ____
   ii. Particulars of Post Office/Sub-Post Office________________________________
   iii. Particulars of Head Post Office concerned ________________________________
   iv. Savings Bank Account (Pension) No____________________________________
   v. Amount of Pension per month (in words)_________________________________
   vi. Designation, Office at the time of retirement________________________________
2. I agree to undertake that any amount of excess/wrong payment of pension, if credited to my above SB Account, may be recovered or withdrawn from the said Savings Bank Account by the said Postmaster/Sub-Postmaster.
3. This authority shall remain in force until due notice in writing of its revocation is given by me.

____

Signature of the
Government Servant/Pensioner
(with name, father's name & address)

____

Signature of Joint
Joint holder
(with name, father's
name & address)

Date:

1. Signature of witness
   (with name, address)

2. Signature of witness
   (with name, address)

APPLICATION FORM FOR RESTORATION OF COMMUTED PENSION

From

To

Dear Sir,

Subject: Restoration of commuted pension 15 years after date of commutation

Ref: Order No. 34/2/86 – P& PW dated 5-3-1987 of the DoP & PW

In terms of the Order under reference above, I request you to restore my commuted pension, for which I give below all the required particulars

1. Name and address ______________________________________
   ____
   ____
   ____
   ____
2. Date of retirement ______________________________________
3. Date of commutation ______________________________________
4. Amount of pension commuted ___________________________________
5. Pension Payment Order (PPO) No.______________________________
6. Original pension amount before commutation.______________________
7. Accounts Officer who issued the PPO.____________________________

Yours faithfully

Date: Signature of the pensioner.

Note: The application is not necessary, if the date of payment of commuted value of pension has been noted in the PPO

APPLICATION TO BE SUBITTED BY PENSIONERS FOR ENDORSEMENT OF PARTICULARS OF SPOUSE FROM POST-RETIRAL MARRIAGE AND CHILDREN BORN AFTER RETIREMENT IN THE PPO

(to be filled in triplicate and submitted to Head of Office which processed pension papers initially)

Sir,

I am to state that I have married/remarried on ______________, I give below the requisite particulars of my spouse for necessary endorsement on my PPO.

I also enclose 3 copies of passport size join photograph with my spouse duly attested for necessary action.

1. Name of the pensioner (as recorded in PPO)________________________________
2. Full present address____

   ____
3. Date of retirement____
4. i) PPO No.and date ____

   ii) Name of PPO Issuing Authority____
5. Name of the Pension Disbursing Authority___________________________________
   i) Station _______________________________
   ii) Treasury/DPDO/PAO/PSB, as the case may be __________________________
6. (a) Details of family (as recorded in PPO)

Sl No	Name(s) & address of members of family	Relationship with the pensioner	Marital status (in case of daughter)	Date of Birth of children	Whether the child/children physically handicapped

(b) If the application is for inclusion of post-retiral spouse, the date of death/divorce of the previous spouse (attested copies of Death Certificate/divorce decree to be enclosed)

7. Particulars of spouse from post-retiral marriage:-

i) Name____
ii) Date of marriage with the pensioner (please attach attested copy of Marriage Certificate)______________
iii) Joint photograph of the pensioner with the spouse referred to, at item (i) above duly attested

8. Particulars of children born after retirement

Sl No	Name(s) & addresses of Post-retrial members of family	Relationship with the pensioner	Date of Birth of children	Whether the child/children is/ are physically handicapped

(Please attach attested copies of Birth Certificates)

9. Verification
I certify that the particulars furnished above are correct.

Yours faithfully

Signature of pensioner

Attested by:
1. Signature
Name (in block letters)
Address:

Place:
Date :

2. Signature
Name (in block letters)
Address:

Note: Attestation should be done by two Gazetted Government servants or by two respectable persons in the Town/village or paragana in which the application resides.

APPLICATION FOR OPENING A JOINT ACCOUNT (PENSION) IN A PUBLIC SECTOR BANK

APPLICATION FORM

(For crediting Pension to Joint Account operated by Pensioner with his/her spouse.

_______________________________ (Bank)
_________________________________ (Branch and Address)
____

Dear Sir/Madam,

Sub: payment of pension under PPO No.___________ through your Bank Branch.

I wish to receive my Pension under PPO No.________________ by getting it credited to the Saving/Current Bank Account No.__________________ which is operated jointly in your Branch by me and my spouse Mr. /Mrs____________________ in whose favour an authorization for Family Pension exists in the Pension Payment Order (PPO).

I have read and understood the contents of the Government of India, Ministry of Finance, Department of Expenditure, Central Pension Accounting Office O.M No. CPAO/Tech/ Amendments/Sch. Book/200506/69 dated 09.06.2005 which contain the following terms and conditions: “Once Pension has been credited to Pensioner’s Bank Account, liability of the Government/Bank ceases. No further liability arises, even if the spouse wrongly draws the amount.”

a. As Pension is payable only during the Life of a Pensioner, his/her death shall be intimated to the Bank at the earliest and in any case within one month of the demise, so that the Bank does not continue crediting monthly Pension to the Joint Account with the spouse, after the death of the Pensioner. If, however, any amount has been wrongly to the Joint Account, it shall be recoverable from the Joint Account and/or any other account held by the Pensioner/Spouse either individually or jointly. The Legal Heirs, Successors, Executors etc., shall also be liable to refund any amount, which has been wrongly credited to the Joint Account.

b. Payment of arrears of Pension (Nomination) Rules 1983 would continue to be applicable to a Joint Account with the Pensioner’s spouse. This implies that if there is an accepted nomination in accordance with Rules 5 and 6 of these Rules, arrears mentioned in the Rules shall be payable to the nominee.

I accept the above terms and conditions. My spouse too, in token of having accepted these terms and conditions, has put his/her signature below.

Place: 1. Signature of Pensioner

Date:

2. Signature of Spouse

LIFE CERTIFICATE TO BE SUBMITTED BY PENSIONER

Certified that I have seen the Pensioner Shri/Smt_______________ (Name of the Pensioner) holder of Pension Payment Order No. _____________ and that he/she is alive on this date.

Place _______________ Name _________________

Date________________ Designation of Authorized Officer (with seal)

FORM – II
NON-EMPLOYMENT CERTIFICATE
(FOR PAYMENT THROUGH POST OFFICE)

* I declare that I have not received any remuneration for serving in any capacity in an establishment of the Central Government or a State Government or a Government Undertaking or from a Local Fund during the period December to May, 20__ / June to November 20__

* I declare that I have been employed/re-employed in the Office of ___________ and was in receipt of the following emoluments during the period ___________

* I declare the I have accepted commercial employment after obtaining/without Obtaining sanction of the Government (to be furnished by Central Service Class I Officers during first one year from the date of retirement).

* I declare that I have/have not accepted any employment under any Government Outside India after obtaining/without obtaining sanction of the Government (to be furnished by Central Service Class I Officers only).

Signature _____________

Place: ____________

Name of the Pensioner____________

Dated:____________

PPO No. ________________

REVISED FORMAT OF PENSION CALCULATION SHEET

1. Name ________________________

2. Designation ___________________

3. Date of Birth ___________________

4. Date of entry in to Govt. Service. _______________

5. Date of Retirement __________________________

6. Length of qualifying service reckoned
   for Pension/Gratuity (as indicated in PPO)_________________

7. Emoluments drawn during the last 10 months ______________

8. (1) Emoluments (Pay last drawn) ____________
   (2) Average emoluments for Pension (as indicated in PPO) _______________
   (3) Pension admissible _____________

Calculation to be shown as follows:
50% of the emoluments as at 8(1) or 50% of average emoluments as at 8(2)
. whichever is more

9. (1) Emoluments for gratuity (as indicated in PPO) ________________
   (2) Family Pension admissible ___________________________

Calculation to be shown as follows:-

a) Ord. Family Pension: Pay last drawn x Prescribed Percentage
   (Subject to prescribed min & max)

b) Enhanced Family Pension _________________
   Family Pension at ordinary rate as at (a) above x 2 or 50% of the last pay drawn whichever is less, subject to prescribed minimum and maximum as per Rule 54.

Counter signed   Head at office

P.A.O

FAMILY PENSION FOR PHYSICALLY HANDICAPPED AND MENTALLY RETARDED CHILDREN

To avail the facility an endorsement is necessary in the PPO. Application should be addressed to the original Pension Sanctioning Authority (not to the Accounts Officer) along with a Medical Certificate in the format furnished below from a Medical Board Comprising of a Medical Superintendent as a Chairman and 2 other members out of which atleast one shall be a Specialist in the particular area of mental or physical disability including mental retardation, with the original PPO. The Pension Sanctioning Authority will sanction Family Pension, forward a copy of the same to the Pensioner and endorse another copy to the Accounts Officer for making necessary entries in the PPO.

FORMAT

Certified that I/We, ________________________________
Dr./Drs____ examined this day
(date)________________ Sri/Smt ___________________________ Son/Daughter of
Sri/Smt_______________________________ and I/We find that he/she is suffering from (nature of disease) ________________________ and in my/our opinion that he/she is permanently/temporarily disabled.

Or

He/she is suffering from mental disorder:-
Nature of disability and to what extent __________________________________
Details of mental disorder and its percentage _____________________________
His/her age according to his/her statement is ________ years and by appearance about _________ years.
Having regard to his/her physical disability/mental disorder Sri/Smt. ________________________ is hereby certified to be completely incapacitated from earning his/her livelihood.

Signature

Name/Names of the Doctor/Doctors and
Designation of Medical Board with Seal

Place:
Date:

Signature of the child

TEMPORARY PERMIT (CGHS)

No.

Date:

Authority for medical facilities under the CGHS for Pensioners.

This will be valid for a period not exceeding six months from the date of issue.

Shri/Smt.______________________

Is a pensioner and has been issued CGHS Identify Card No.______________

He/she and the under mentioned entitled members of his/her family are expected to stay in _______________________________ for a period of _____________ months ____________days from _________ to _____________

	Name	Age	Relationship
1.			
2.			
3.			
4.			

Signature/Name & Designation
Of the issuing authority

Signature of the
Chief Medical Officer/
Medical Officer – I/C
CGHS Dispensary concerned

Signature of the
Chief Medical Officer I/C
of the CGHS Dispensary
to which transferred

ADDTION / DELETION TO FAMILY (CGHS)
(IN DUPLICATE)

1. No. of the Identify Card.:

2. Name of the Govt. Servant:

3. Office / Department:

4. New Addition / Deletion :

Name	Date of Birth	Relationship	Identification marks
1.			
2.			
3.			
4.			
5.			

Signature of Govt. Servant/Pensioner:

Date:

Remarks:

Signature and designation of Issuing Authority:

Signature of Medical Officer I/C of the Dispensary:

FORM OF APPLICATION FOR THE GRANT OF FAMILY PENSION, 1964, ON THE DEATH OF A GOVERNMENT SERVANT/PENSIONER

1. Name of the applicant ____________________________
   (I) Widow/Widower __________________________
   (II) Guardian if the deceased
   Person is survived by child or children ________________________

2. Name and age of surviving widow/widower and
   Children of the deceased Government servant/Pensioner ________________________

Sl. No.	Name	Relationship with the deceased person	Date of Birth by Christian era

3. Name and No. of the PPO of the
   deceased Pensioner ________________________________

4. Date of death of the Government
   Servant/Pensioner ________________

5. Office/Department/Ministry in which the
   deceased Government servant/Pensioner last served _____________________

6. If the applicant is guardian, his date of birth and relationship with the deceased .
   Government servant/Pensioner

6-A. If the applicant is a widow/widower the
   amount of service Pension which she/he
   may be in receipt on the date of death
   of the husband/wife ____________________________

7. Full address of the applicant ________________________
____
____
____

8. Place of payment of Pension and Gratuity (Treasury, Sub-Treasury or Public Sector Bank Branch, Post Office and Pay and Accounts Office) _____________________________

9. Enclosures
   i) Two specimen signatures of the applicant duly attested (To be furnished in two separate sheets).
   ii) Two copies of passport size photographs of the applicant, duly attested.
   iii) Two slips each bearing left hand thumb and finger impressions of the applicant, duly attested.
   iv) Descriptive Roll of the applicant, duly attested, indicating (a) height and (b) personal marks, if any, on the hand, face,etc.
   (Specify a few conspicuous marks, not less than two, if possible)
   (To be furnished in duplicate)
   v) Certificate (s) of age (in original with two attested copies) showing the dates of birth of the children. The Certificate should be from Municipal Authorities or from the Local Panchayat or from the head of the Recognized School if the child is studying in such school. (This information should be furnished in respect of such child or children, the particulars of whose date of birth are not available with the Head of Office)

10. Indicate whether Family Pension is admissible from any other source—Military or State Government and/or a Public Sector Undertakings/Autonomous Body/Local Fund under the Central or a State Government.

11. Signature or *left hand thumb-impression of the applicant
   - *To be furnished in case the applicant is not literate to sign his name*

In the case of re-marriage of the widow, while applying for Family Pension on behalf of the minor child, the widow should furnish (i) the date of her re-marriage, (ii) name of the Treasury/'Sub-Treasury at which payment is desired and (iii) her full address in the application for Family Pension. It is not necessary to furnish a fresh application or the documents as they are already available with Pension papers on which Family Pension was originally admitted to her

12. Attested by:

	Name	Full Address	Signature
i)	__________________	________________________	________________
		________________________	
		________________________	

ii) ____________________ ____________________________ __________________

____

____

____

13. Witnesses:

	Name	Full Address	Signature
i)	______________________	_______________________	__________________
		____________________________	
		_____________________________	
		_____________________________	
ii)	______________________	_______________________	__________________
		_____________________________	
		_____________________________	
		_____________________________	

Note: Attention should be done by two Gazetted Government servants or two or more persons of respectability in the Town, Village or Pargana in which the applicant resides

Additional documents to be submitted along with application

1. *Death Certificate*
2. *Pensioner's half of PPO for verification and return*
3. *Non-remarriage Certificate*
4. *Letter of undertaking in connection with crediting Pension in S.B Account if Family Pension is preferred to be drawn through S.B Account.*
5. *Certificate regarding employment status and Income Certificate if the claimant is not spouse.*

BSNL EMPLOYEES MEDICAL REIMBURSEMENT SCHEME

(To be submitted in Duplicate)

Registration Form for Serving Employees

1. Name of Employee ________________________________

2. Designation ___________________________

3. Place of Posting
   (Mention complete Office address) _____________________________
   ____
   ____
   ____

4. Staff No. ______________________

5. Basic Pay ______________________

6. Telephone No. Office ___________________ Residence: ____________

7. Details of Family Members:

Sl. No.	Name	Date of Birth	Relationship with employee	Blood Group (if available)

8. Details of Chronic: diseases, if any
   a)
   b)
   c)
   d)

9. Options for Outdoor Treatment (Under BSNLMRS): (tick√ any one of i), ii) or iii)

i) Outdoor/Domiciliary Treatment from RMP's; Reimbursement against Vouchers. (as per Para 2.1.0)
(Annual limit is One month's Salary (Basic+D.A)-starting month of Financial Year) or

ii) Outdoor/Domiciliary Treatment: Entitlement without Voucher, (as per Para 2.1.1)

(50% of the admissible amount as in Para 2.1.0 above—paid in cash in four equal installments at the end of each quarter) or

iii) Outdoor/Domiciliary Treatment from P&T Dispensaries. (as per para2.1.2)

Declaration:

I hereby declare that above mentioned members of my family are fully dependent on me, i.e., their income from all sources does not exceed Rs.1,500/- per month. If the above information is found to be false at any time, Company can take action against me as per Rules or as deemed fit.

Place: Signature:

Date: Name:

Designation:

For Office use only

Registration No.Issued:________________

Card Issued: Yes/No: Card No.__________________

Date of Issue:_______________________________ Signature of Issuing Authority

MEDICAL REIMBURSEMENT CLAIM FORM
FOR OUTDOOR TREATMENT (BSNL)

1. Name of the Employee:
2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + D.A)/Pension (as on 1.04.04):
5. Place of Duty:
6. Name of Patient:
7. Relationship with Employee:
8. Age:
9. Reimbursement claimed under:

(Tick√ relevant box)

- Treatment from RMP (as per Para 2.1.0) ☐
- Treatment from P & T Dispensary (as per Para 2.1.2) ☐

10. Nature of illness:
11. Name of Doctor/Hospital:
12. Details of Claim:

(attach prescription, vouchers, etc., in duplicate)

	Voucher No.:	Amount Rs.
• Consultation:		
• Diagnostics/Tests:		
• Medicines:		
• Appliances:		
• Special treatment (e.g., Physiotherapy, Yoga etc.)		
• Others:		
Total		

(Rupees___________________________)

Declaration:
I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for whom medical expenses are incurred is wholly dependent on me.

(Signature of Employee)

MEDICAL REIMBURSEMENT CLAIM FORM
FOR INDOOR TREATMENT (BSNL)

1. Name of Employee:
2. Designation:
3. Reg.No:
4. Salary (Basic Pay + D.A)/Pension (as on 1.04.04):
5. Place of Duty:
6. Name of the Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of Treatment: From_________ To _______________
    (Certificate issued by the Medical Officer in-charge of the Hospital as per enclosed proforma is to be attached)
12. Details of claim:
    (attach prescription, vouchers, etc., in duplicate)

	Voucher No.:	Amount Rs.:
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		
	Total:	

(Rupees__________________________________)

Declaration:
I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for whom medical expenses are incurred is fully dependent on me.

(Signature of Employee)

CERTIFICATE FOR HOSPITALIZATION (BSNL)

(To be completed in the case of patients who are admitted to Hospital for Treatment)

Certificate granted to Mrs. /Mr. Miss____________________________________
husband/wife/son/daughter/mother/father of Mrs./Mr._________________________ employed in the Office of _________________________________BSNL.

PART 'A'

I, Dr ___________________________________ hereby certify:

(a) That the patient was admitted to Hospital on _______________

(b) That the patient has been under treatment at ________________ and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient.

(c) That the patient is/was suffering from ________________ and is/was under treatment from _________ to _____________

(d) That the X-ray, Laboratory Tests, etc., for which an expenditure of Rs._________ was incurred were necessary and were undertaken on my advice at ____________________ (name of Hospital or Laboratory);

Signature and Designation of the
Medical Officer In-charge of the
Case at the Hospital

APPLICATION FORM FOR MEDICAL ADVANCE (BSNL)

1. Name of Patient:
2. Relationship with Employee:
3. Age:
4. Nature of Disease (for which hospitalization is required)

:

5. Name of Hospital:
6. Name of Employee:
7. Designation:
8. Salary (Basic Pay + DA). Pension:
9. Basic Pay:
10. Estimated cost of Treatment
    (Enclose original copy of Hospital's Estimate):
11. Amount of Advance required for Treatment:

Signature:
Designation:
Section:
Tel.No.

AUTHORISATION LETTER FOR TREATMENT IN HOSPITAL

This is to Certify that Shri/Smt.________________________________ (Name of the patient), age_____ is the Husband/Wife/Son/Daughter/Mother/Father of Shri/Smt___________________ an employee of BSNL. He/she may be admitted in (Hospital's Name) __________________________ as per his/her room entitlement i.e., ____

He/She may be charged as per agreed rates with BSNL.
Bills as per agreed rates may be sent to this Office for payment.

(Signature of the Competent Authority)

FORM OF APPLICATION TO THE LOCAL LEVEL COMMITTEE BY A PARENT, RELATIVE OR A REGISTERED ORGANISATION FOR APPOINTMENT OF GUARDIAN FOR A PERSON WITH MENTAL RETARDATION.

Date:

From

To
The Local Level Committee

Sir/Madam,

______________________ is a person with disability and requires protection of his person and property through a Guardian. We hereby request that ____________________ be appointed as Guardian of the said _________________________ for the protection of his person/property.

We furnish hereunder further details and request early decision:

1. Particulars of the person to be provided Guardian
   Name:
   Age:
   Nature of disability:
   Address:

2. Particulars of the person proposed to be appointed as Guardian
   Name:
   Age:
   Relationship with ward, if any:
   Address:

We enclose herewith Disability Certificate to the said _________________ obtained from _____________

Yours faithfully,

Authorised signatory

Witness
1st Witness

2nd Witness

Name:
Designation:
Office Stamp:

Consent of the person proposed to be appointed Guardian

I hereby agree to be the Guardian of the person and property of _____________________ and shall discharge my obligations with due diligence.

Signature:
Name:
Date:

Consent of the Guardian, if any, to the aforesaid proposal

I hereby agree to the above proposal to appoint _______________________ as the Guardian of ________________________________

Signature:
Name:
Date:

Application for CGHS Card for Pensioners of Central Government

CGHS Card No. while in service: ________________________

1. Name of the Applicant: ________________________
2. Category: Pensioner Others (Pl. Specify)
3. Name of Department/Service from where retiring/retired: ____________________
4. Pay and the Pay Band: _________________ Grade Pay: ____________________
   Likely Pension: Per month__________________
5. Residential Address: ____
   ____
6. Telephone Number: (R) (M)
7. E-mail ID:
8. Date of Superannuation:______________
9. Details of Family
   (*Please see definition of Family before filling up this column.)

Sl. No.	Name of Family Member	Relationship To CGHS Card Holder	Date of Birth (Compulsory)	Blood group (optional)	Ben.ID.No. if Plastic Card issued while in service
1.		Self			
2.					
3.					
4.					
5.					

(# Please attach Proof of age of Persons, (except for spouse), mentioned above)

10. Are all the persons whose names are given above are dependent upon you and are residing with you? Yes / No

[Please attach valid proof of their staying with you, like copy of Ration Card/Election ID/Passport/Identify Card issued by College/School/University/Bank Pass Book, etc., (issued within the last six months)]

11. Paste one stamp size Photograph of each member of Family (including self) whose names are proposed to be included (in the same sequence as mentioned in Col. 9 above) as part of your family in the space given below.

Name	Name	Name	Name	Name
S.No.	S.No.	S.No.	S.No.	S.No.

I undertake to intimate to CGHS immediately if there is any change in dependency criteria of my family members included in this application form. If I fail to intimate and if the CGHS comes to know of the change, then the CGHS facility is liable to be withdrawn by the CGHS and the CGHS and/or appropriate authority will be free to initiate any action against me.

I undertake to surrender the CGHS Card(s) on ceasing to be eligible for CGHS benefits.

I certify that the information furnished by me in this application has been verified to be correct and that no information has been concealed or has been misrepresented and I stand by the same.

D.D bearing No. _____________ dated ________________ drawn on Bank
_____________________ Branch ___________________/ Postal Order No
____________________ for Rs. _______________________
(Rupees____ only)

Signature of Applicant

(To be filled by the sponsoring authority)

The information furnished by the applicant has been verified and found to be correct. The applicant and his/her family members are entitled to avail CGHS facility after retirement.

Shri. /Smt. /Kumari.___________________ Designation ___________ was employed in this Ministry/Department/Organisation. It is ________________recommended that Pensioner CGHS Card be issued to Shri. /Smt./Kumari __________________. I am authorized sponsoring authority in the matter and approval of the competent authority has been obtained.

No.

Date Signature and Name of the Sponsoring Authority

Designation (Stamp) with Tel no.

To

The Additional Director, CGHS (HQ), 9, Bikaner House Hutments, Shahajahan Road, New Delhi

The Additional Director /Joint Director of (Name of the CGHS city to be entered)

(To be filled by CGHS)

Verified-by Authorized Signatory, CGHS Card valid up to_____/_____/_____/ for rest of Life

CGHS Dispensary Allotted____

Entitlement: General ward / Semi-private Ward /Private Ward in Private empanelled Hospitals.

Entitled / not entitled to Nursing Home Facility in Government Hospitals.

Signature

Application for CGHS Card

 Applying for New CGHS Card In case of new Pensioner's Card- CGHS No. While in service _________________

 Applying for New Card to replace_____________________ existing CGHS Card No. ______________________

1. Name of the applicant:________________________________
2. Category Department Service

   Pensioner Other (Pl specify)

   (Please Tick√ Department if you are posted in the Ministry of Health & Family Welfare/DGHS/CGHS)

   (Please Tick√ Service if you belong to any specific organized service)

3. Name of Department/Service
4. Designation_____________________ Gazetted Non-Gazetted
5. Scale of Pay___________________

   Present Pay___________________

6. Last Pay/basic Pension (in case of Pensioner): _____________
7. Official address:______________________________________

   ____

8. Residential address:______________________________________

   ____

9. Telephone Number: (O)_______________ ®________________

   (M)

10. E-mail ID____

11. Date of Superannuation: Date___ Month___ Year______

12. Are you on Deputation (Central Deputation) Yes/No

13. If yes, likely period of completion of Deputation ____________________

14. Are your service transferable to other Cities: Yes/No

15. Details of Family

(* Please see definition of Family before filling up this column)

Sl. No.	Name of Family Members	Relationship to CGHS Card Holder / Self	Date of Birth/ Blood Group
1.			
2.			
3.			
4.			
5.			

(# please attach Proof of age of persons mentioned above)

16. Are all the persons whose names are given above are dependent upon you and are residing with you? Yes/No

(Please attach proof of their staying with you, like copy of Ration Card/ Election ID/Passport/Identity Card issued by School/College/University/ Bank Pass Book etc.)

17. Paste one ID card size of Photograph of each member of Family (including self) whose names are proposed to be included as part of your family in the space given below.

APPLICATION FOR ADMISSION TO CGHS (PENSIONERS)

To

The Additional Director,
Central Govt. Health Scheme.
____
____
____

Dear Sir,

I along with the members of the family whose particulars are given at the Sl.No.5 may please be admitted to CGHS on payment of subscription on the basis of last PAY DRAWN/PENSION/FAMILY PENSION*. My particulars are as under:

1. Name of the Head of family:________________________________
2. Residential Address: ____

   ____

3. In the case the applicant is a Pensioner,

   (a) Date of retirement:____________

   (b) Ministry/Dept./Office:_________________

   (c) Gross pension, if fixed:___________________

   (d) P.P.O No. ____________________

4. In the case the applicant is Family Pensioner:

   (a) Name of the diseases Govt. Servant:_______________________________

   (b) Date of Death of the deceased Govt. Servant :____________________

   (c) Ministry/Dept./Office: ______________________

   (d) Post held at the time of retirement:____________________

   (e) Pay last drawn at the time of retirement: ________________________

   (f) Relation of the applicant with the deceased Govt. Servant:_____________________

   (g) Amount of family pension: at the enhanced rate:__________________

   (Please also specify the date upto which enhanced

   family pension is admissible):_______________

   (h) F.P.P.O No. __________________

5. Details of family according to the term family

Sl.No.	Name	Age	Date of Birth	Relationship
1.				
2.				
3.				
4.				
5.				

I declare that:

i) I will abide by the Rules and Regulations and Modifications of the services which may be issued from time to time.

ii) *I will deposit my contribution on six monthly/yearly installments.

iii) *I wish to avail of CGHS facilities on the basis of last pay drawn/Pension.

iv) *I have not applied for CGHS card previously/ I have surrendered my CGHS identity Card issued to me from my Office while in service and the payment of contribution has been made upto the date of surrender of Card.

v) I hereby undertake to surrender CGHS Card being issued to me if not required, in the Dispensary concerned. In case the Card is not surrendered before the expiry of validity period and Card is retained by me, even if no facility is availed by me, I undertake to pay the CGHS contribution for the intervening period.

- Strike off * Not applicable*

Place:

Date: Signature of Applicant

AFFIDAVIT

(To be attested by a Notary Public or Gazetted Officer)

I ____ solemnly affirm that I am, and my

dependants whose names are given below, are residing in __________________ (place)

and my address is ____

____

Sl. NO.	Name of the Govt. servant and also dependants	Age	Date of Birth	Relationship

Place:

Date:

Signature of Applicant

Attested by

Signature with name and Office Seal

PREFERRING OF MEDICAL CLAIMS BY THE CGHS BENEFICIARIES (BOTH SERVING/PENSIONER) AND REIMBURSEMENT THEREOF (CGHS)

(G.o.I. M.H.&F.W., Lr. No. Misc. 3/04/R & H/CGHS/CGHS(P), dated. 9.3.04)
(G.o.I. M.H. & F.W. No. 4.18/2005-C&P (Vol.1 pt (1) Dated. 20.2.09)

I am directed to forward herewith the Medical 2004 Form, Checklist, and Essentiality-cum- Statement of expenditure Certificate to enable the CGHS beneficiaries (both serving/Pensioner) to prefer their medical claims for reimbursement from the Government.

In view of the above, the CGHS beneficiaries may be requested to henceforth prefer their medical claims as per the revised Medical 2004 Form, Checklist and Essentiality-cum-Statement of expenditure Certificate being circulated with this letter.

Central Government Health Scheme
Checklist for reimbursement of medical claims

1. CGHS Token No. and Place of issue: ______________________

2. Validity of CGHS Card: from ____________ to ___________
   (For Pensioner) and Entitlement Pvt/Semi Pvt. /General

3. Full Name of Card Holder: ______________________________
   (BLOCK LETTERS)

4. **S**tatus (Government Servant/Pensioner/Other): ____________________________

5. The following documents are submitted [Please tick**(√)** the relevant column at 4 :

   A) Medical 2004 Form : Yes/No

   B) Photocopy of CGHS Card : Yes/No

   C) No. of Original Bills : ______

   D) Copy of discharge summary : Yes/No

   E) Copy of Referral by Specialist/CMO : Yes/No

   F) Whether the Hospital has Given break-up for Lab Investigations : Yes/No

   G) Original papers have been lost hence the following documents are submitted-
      I. Photocopies of claims papers : Yes/No

      II. Affidavit on Stamp Paper : Yes/No

H) In case of death of Card holder, the following documents are submitted-

I. Affidavit on Stamp Paper by Claimant : Yes/No

II. No Objection from other legal heirs On Stamp Paper : Yes/No

III. Copy of the Death Cerficate : Yes/No

Date__________

Signature of CGHS Cardholder
Tel. No. (O)_______________
®________________
(M)
E-mail Address:_________________________

Name of the Bank___________________________________ Branch___________________________
S.B A/c No.____________________________

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES

Computer No.____________________

(To be filled by the Claimant)

1. CGHS Token No. and place of Issue : ______________________________
2. Validity of CGHS Token Card and entitlement : From______________________________ : To_________________________ Pvt./SemiPvt./General
3. Full name of the Card Holder (Block Letters) :________________________________
4. Full address :______________________________
:______________________________
:______________________________
:______________________________
5. Telephone No. (O)____________________ ®_________________ (M)______________
6. E-mail address, if any.____________________________________
7. Name of the Bank____________________________________
Branch___________________S.B. A/c. no._________________
Branch MCR code_______________ Ph no. of Bank________________
8. Name of the patient and relationship with the Card Holder____
9. Status tick(√) (Government servant/Pensioner/serving employee or Pensioner of Autonomous Body/Member of Parliament/Ex. M.P./Ex. Governor/Former Judge of Supreme Court/Former Judge of High Court/Freedom Fighter/Legal Heir/others).
10. Basic Pay/Basic Pension :______________________

11. Name of the Hospital with Address :________________________________

12. Date of admission___________ Date of discharge____________

(In case of Indoor Treatment only)

13. Total amount claimed :________________

a) OPD Treatment :_________________

b) Indoor Treatment :__________________

14. Details of Referral :__________________

15. Details of Medical advance, if any :__________________

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a CGHS beneficiary and the CGHS Card was valid at the time of treatment. I agree for the reimbursement as is admissible under the Rules.

Date: ___________ Signature of CGHS Card Holder

KARANATAKA POSTS AND TELECOMMUNICATIONS

PENSIONERS' ASSOCIATION ®

(Formerly RMS Pensioners' Association)

(Registered under the Karnataka Societies Regn. Act 1960_Regn. No. 1069/98-99)

Registered as "a Wholly Charitable Trust" U/s. 12A of I.T. Act 1961

Affiliated to

All India Federation of Pensioners' Assns, Chennai

All India Central Confederation of Pensioners' Associations. Delhi

Coordination Committee of Central Government Pensioners' Associations. Karnataka

#1397. 23rd Main, Banashankari 2nd Stage, Bangalore-560070

B.Sadashiva Rao, IPS (retd.)	**N.Bhaskaran**	**S.M.Vittal Rao**
President	Secretary	Treasurer
Ph. :26626333/ M: 9945018275	Ph: 26716198	Ph.: 28463468

Form of Application for Life/Associate Life Membership

LM / ALM No. ______________________

Affix stamp size colour photo here

Sir,

I wish to become a LIFE member of your Association.

1. Name in full (in capitals):__________________________

2. (i) Whether pensioner or
   Family Pensioner: __________________

   (ii) PPO/FPPO No. : _________________

3. Address (Permanent) : ____

____

4. Father's name (Husband's/Wife's
name in case of family pensioner): ________________________________

5. Exact date of birth : _________date ___________ month ___________ year

6. Date of retirement : _________ date___________ month ___________ year

7. (I) Name of the office/place
where the pensioner last worked: ________________________

(II) Designation: ____________________________

(III) Name of the Ministry/Department: _________________

8. Name of the next eligible family pensioner
(Wife's/Husband's Name): __________________________

9. Telephone number (Residence): ____________________ Mobile______________

10. Telephone number (Office, if any): ___________________

I am herewith paying/remitting by cash/cheque/DD/MO. A sum of Rs.610/- being the life membership fee of Rs.500, Rs.10 towards admission fee, and Rs.100 as subscription towards the monthly journal. 'PENSIONERS' 'CHAMPION' for one year.

I declare that I have read and understood the Memorandum of Association as also Rules and Regulation of the Association and I agree to abide by them.

Place:

Date: Signature

1. One stamp size colour photo to be affixed on this application form.
2. Pensioners of Central Govt. Depts. Other than P & T are admitted as Associate Life Members.
3. Amount/Cheque to be sent to the Treasurer in the given address. Outstation applicants should remit either by M.O.//Bank DD only.
4. Particulars of remittance CASH/MO/CHEQUE/DD-No. _____________ Date __________
   Bank's Name ____

5. The next eligible family pensioner is entitled to have the life membership in his/her name automatically transferred upon the death of the member without any extra payment.

   The amount can be remitted by MO or crossed cheque or DD drawn in favour of KARNATAKA POSTS AND TELECOMMUNIATIONS PENSIONERS' ASSOCIATION and both the application form and the cheque to be posted to:

   Sri. S.M. Vittal Rao, Treasurer, K P&T PA No. 114, II Main Road, K.H.B. 707, IV Phase, Yelahanka Satellite town, Bangalore – 560106. (Phone No. 28463468)

FOR OFFICE USE ONLY

1. Membership Number allotted LM/ALM No. ________________________________
2. Receipt No. ______________ dated ______________ issued for amount of Rs.___________________________ Received by Cash/MO/DD/cheque No.__________________________ dated_____________________
   Bank's Name ___________________________

ADMITTED

Treasurer Secretary

Date: PRESIDENT