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

i) 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