Annexure A

Medical Card
Contributory Scheme for Post Retirement Facilities for Executives

Registration No:

Photograph of the Retired Executive	Photograph of the spouse	Photograph of the nominee, if any

Name of the Retired Executive with Employee No. :
Name of spouse :
Date of retirement :
Designation at the time of Retirement :
Scale of pay and basic pay as on the date of retirement :
Company along with /Mine/Establishment/Unit from where Retired :
Company/Establishment where Registered for Medical Benefits under the scheme :
No. and date of Demand Draft remitted with name of the Issuing bank :
Permanent Address :

Present Address with telephone No. :

Name of the nominee with relationship, if any :

Address of the nominee :

Company opted for claiming reimbursement :

Declaration

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 (applicable for executives who have retired prior to 01.01.07)

(Signature of Retired Executive) (Signature of the Spouse) (Signature of the nominee)

For office Use

Received Rs. .... Vide Draft No.......................... dated ....

Date, Stamp & Signature of receiving Officer

Validity Period of the Card
From .... To ....
Date of issue ....

Signature of Issuing Authority with seal

Annexure B-1

Contributory Scheme for Post Retirement Medical Facilities for Expenses (Clause 6.1)

CLAIM FORM FOR PAYMENT OF OUTDOOR TREATMENT EXPENSES

Period of Claim: Half year ending 30th June__________ / 31st December____________

1. Name & grade of the retired executive/spouse :
2. PIS No. :
3. Registration No. of Medical Card :
4. Fixed Amount for Outdoor/Domiciliary treatment : Based on date of retirement (Rupees)
5. Amount Claimed (Rupees/Paise) :
6. Name of Bank and Branch with single-owned : Savings Bank Account Number where the amount Shall be credited AND Present Address at which Cheque is to be sent :

(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. I 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

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

Chief of Medical Service

(To be filled in by the Accounts Department)

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

Accountant Sr. A.O/A.O. Date :

Annexure-B/2

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

Name & Code :

Registration of Medical card :

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

1.	Name of the patient	:	
2.	Relationship with the Retired 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 prepared for each patient and each spell of treatment.

(To be certified by the retired executive)

I hereby declare that :

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) I 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 reasons.
vi) 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 executive/ living spouse in case of death of retired executive)

The claim has been scrutinized and recommended for payment of Rs.__________ (Rupees ______________ __________) only

Chief of Medical Services

(To be filled in by the Accounts Department)

Claim passed for payment of Rupees (in words) ______________________
(in figures)______________________

Accountant Sr. A.O./A.O. Dated:

Annexure-B/3

(DETAILS OF THE AMOUNT CLAIMED)

			HOSPITALIZATION CASE	AMOUNT	
	Rs.	P.		Rs.	P.
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.**			1. COST OF MEDICINES		
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 executive/ living spouse in case of death of retired executive)

DETAILS OF AMOUNT DISALLOWED

Reason	Amount
1.	
2.	
3.	

COAL INDIA LIMITED
"COAL BHAWAN"
10, NETAJI SUBHAS ROAD
KOLKATA – 700001

No. CIL/C-5A/125/CPRMSE/222

Date: 14.11.2013

OFFICE ORDER

Sub: **CONTRIBUTORY POST RETIREMENT MEDICARE SCHEME FOR EXECUTIVES OF CIL AND ITS SUBSIDIARIES (CPRMSE)**

The Board of Directors of CIL in their 289th Meeting held on 18.09.2012 approved the modifications/ additions in the **Contributory Post Retirement Medicare Scheme for Executives of CIL and its Subsidiaries (CPRMSE)**. The same is also communicated as per the Office Order No. CIL/C-5A (PC)/CPRMSE/207 dated 28.12.2012.

As per Clause 5.4 of the **Contributory Post Retirement Medicare Scheme for Executives of CIL and its Subsidiaries (CPRMSE)**, **"Life Certificate"** is required to be submitted annually. The same is revised in order to accommodate the nature of membership (single/ couple).

The revised format of the **Life Certificate** is published in website www.coalindia.in. A copy of the same is enclosed for wide circulation.

This issues with the approval of Competent Authority.

(Bhagwan Pandey)
GM (P&IR/ Welfare)

Distribution:

1. D(F)/D(T)/D(Mktg)/D(P&IR), CIL, Kolkata
2. D(P)/D(F) ECL/ BCCL/ CCL/ SECL/WCL/ NCL/ MCL
3. D(RD& T), CMPDIL, Ranchi
4. CVO, CIL, Kolkata
5. ED, IICM, Ranchi/ ED (Medical Services), CIL Camp : CCL, Ranchi
6. ED (Corporate Services) (Internal Audit), CIL, Kolkata
7. CGM/TS to Chairman, CIL, Kolkata
8. CGM, NEC, Margherita
9. GM(P/EE), ECL/ BCCL/ CCL/ SECL/WCL/ NCL/ MCL/ CMPDIL/CIL
10. GM (Telecom), CIL: with a request to upload the same in CIL website
11. GM (F), CIL, Kolkata
12. GM(P)(Policy Cell): with a request to facilitate the soft copy to Telecom Department
13. GM(P) Recruitment/ Admin, CIL, Kolkata
14. GM, CIL, New Delhi
15. Company Secretary, CIL, Kolkata
16. Chief Medical Officer, CIL, Kolkata
17. Guard file.

A Maharatna Company

LIFE CERTIFICATE

To whom it may Concern

This is to certify that Shri ________________________________
son of Shri ______________________________ and Smt. ____________________
wife of ____________________________ residing at ________________________
______________________________ are/is known to me and alive at the time of issuing this certificate. The certificate is issued for release of payment for outdoor/ domiciliary treatment under CPRMSE of CIL.

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

Signature of Retd executive Shri/Smt ______________________ : ________________

Signature of spouse : ______________________ : ________________

____

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 from where
the medical facility is obtained
With Seal/Stamp

Date: ______________

Registration No. of Medical Card: CPRMSE/____________________________

Note: Please note that in case of couple membership, signature of the executives and their spouse is mandatory.

सेन्ट्रल कोलफील्ड्स लिमिटेड
CENTRAL COALFIEDLS LIMITED
लेखा विभाग ACCOUNTS DEPARTMENT

सी.सी.एल. के रोकड़ अनुभाग में भुगतान का चालान
CHALLAN FOR PAYMENT IN THE CASH SECTION

वर्गीकरण Classification/Account Head ....

इकाई (यूनिट) Unit ....

पार्टी कोड संख्या Party Code ....

सम्बन्धा अनुभागाध्यक्ष का हस्ताक्षर
लेखा विभाग कार्यालय
Head concerned in the Office of the
Accounts Department

1. पार्टी का नाम Name of the Party ....
2. पत्राचार हेतु पार्टी का पूरा पता
   Full Postal Address of the Party ....
   ....
3. संस्थान का नाम
   Name of the institution ....
4. मोबाइल नं. Mobile No. ....
5. राशि (अंकों एवं शब्दों में)
   Amounts (in figs. and words) ....
6. एन ई एफ टी/आर टी जी एस/चेक/डी डी नं./नगद
   NEFT/RTGS/Cheque/DD No./Cash ....
7. भुगतान का प्रयोजन
   Purpose of Payment ....

जमाकर्ता का हस्ताक्षर
Signature of Remitter

.... के सम्बन्ध में (राशि) रू .... हेतु सी. आर. संख्या ....में अदायगी–आदेश/चेक/ड्राफ्ट/नकद प्राप्त किए एवं रसीद निर्गत की गई।

P.O./Cheque/Draft/Cash received and receipt issued in C.R. No. .... of ....

for Rs. ....

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रोकड़पाल
Cashier

Following are the bank details of Central Coalfields Ltd. Ranchi for transfer of amount through RTGS/NEFT :

Account Name : Central Coalfields Ltd
Account Number : 10106155123
IFSC Code : SBIN0010400
BANK NAME : STATE BANK OF INDIA, CCL CAMPUS BRANCH

Enclosed herewith the Blank Challan , Challan must be duly filled and forwarded from EE department along with RTGS/NEFT details and date for the generation of Cash Reciept.

e - Payment

(TO BE RETURNED TO THE COMPANY)

To
Central Coalfields Limited,
Darbhanga House, Ranchi.

Dear Sir,

REF : AUTHORISATION OF ALL OUR PAYMENTS THROUGH ELECTRONIC FUND TRANSFER SYSTEM/RTGS/CBS/INTRA BANK TRANSFER.

We, hereby authorise Central Coalfields Limited to make all our payments against our bills, Refund of Earnest Money Deposit and Security Deposit through Electronic Fund Transfer System/RTGS/CBS/Intra Bank Transfer. The details for facilitating the payments are given below.

(TO BE FILLED IN CAPITAL LETTERS)

1.	NAME OF THE BENEFICIARY	
2.	ADDRESS (WITH PIN CODE)	
3.	TELEPHONE NO. (WITH STD CODE)	
4.	BANK PARTICULARS	
(A)	BANK NAME	
(B)	BANK TELEPHONE NO. (WITH STD CODE)	
(C)	BRANCH NAME	
(D)	BANK BRANCH CODE	
(E)	BRANCH ADDRESS (WITH PIN CODE)	
(F)	BANK FAX NO. (WITH STD CODE)	
(G)	9 DIGIT MICR CODE OF THE BANK BRANCH (ENCLOSE COPY OF A CANCELLED CHEQUE)	
(H)	11 DIGIT IFSC CODE OF BENEFICIARY BRANCH	
(I)	BANK ACCOUNT NUMBER	
(J)	BANK ACCOUNT TYPE SINGLE OWNED (TICK ONE)	
	SAVING	
	CURRENT	
	LOAN	
	CASH CREDIT	
	OTHERS	
	IF OTHERS, SPECIFY	

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5.	PERMANENT ACCOUNT NUMBER (PAN)											
6.	E-MAIL ADDRESS FOR INTIMATION REGARDING RELEASE OF PAYMENTS											
7.	CCL VENDOR CODE											

I/We hereby declare that the particulars given above are correct and complete. If the transaction is delayed or credit is not effected at all for reasons of incomplete or incorrect information, I/We would not hold the Company responsible. We also agree to bear the bank charges, if any for enabling such transfer.

(AUTHORISED SIGNATORY)

Name :

Date :

Official Stamp :

s

BANK CERTIFICATION

It is certified that above mentioned beneficiary holds a Bank Account No. ______________________ with our branch and the Bank particulars mentioned above are correct.

(AUTHORISED SIGNATORY)

Authorisation No. :

CCL Press 465/18-19 — 10 Pads of 100 Lvs.

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