NATIONAL HANDLOOM DEVELOPMENT CORPORATION LTD

HUMAN RESOURCE DEPARTMENT

MEDICAL REIMBURSEMENT FORM FOR RETIRED EMPLOYEES (OPTB)

Sr No.	Particulars	Details
1	Employee Name (In block letters)*	
2	Last Pay Scale*	
3	Date Of Birth (DD/MM/YYYY)*	
4	Date Of Joining (DD/MM/YYYY)*	
5	Date Of Retirement (DD/MM/YYYY)*	
6	Spouse Name *	
7	Spouse Occupation (Service Govt. or Private)*	
8	Present Address *	
9	E-mail I.D*	
10	Mobile No.*	
11	Total claimed amount.*	

NOTE: - 1. Doctor's prescription and cash memos in original should be attached.
2. Receipts for amounts claimed should be enclosed.
3. Life certificate within a period of three months should be attached.

DECLARATION

1. I 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.
2. If it is found that there is misuse of the benefits under the Scheme by me / spouse, he/she may be debarred from the benefits under the scheme and his/her membership would be cease on finding the same.
3. The statement made in the claim are true to the best of my knowledge and belief.

Date: - …….. **Claimant Signature**

*** All above fields are mandatory.**