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CLAIM FORM FOR REIMBURSEMENT OF DOMICILIARY TREATMENT UNDER POST RETIREMENT MEDICAL BENEFIT SCHEME

Name of the Ex-employee:	
Employee Code No.:	
Date of Retirement:	

I certify that I have incurred a sum of Rs._____ for medical expenses for myself and my Spouse* Mr./Mrs._____ for the period from_____ to _____**.**
Kindly reimburse the said amount in my Bank account as per details below.

Bank A/c No.:	
Name of the Bank:	
Branch Name and Address:	
IFSC No.:	

If the above Bank details are different from the earlier submitted Bank details, please enclose a cancelled cheque.

Date of Claim	
Signature in full	
Name of the Claimant (Employee/Spouse) **(Please "✔" the appropriate option)**	
Address	
E-mail	
Phone No./ Mobile No.	

* Strike off if it is not applicable. In case of death of Ex-Employee/Spouse, kindly mention the name of the deceased_____ and date of death on_____**.**

Note: The claims made by members for reimbursement of Domiciliary Treatment will be processed on self-certification basis. The periodicity of the claim will be twice in a financial year on six months' period, i.e., first claim is to be made in the month of September and second claim is to be made in the month of March in respect of each financial year. Such self- certification should be submitted by the members within 1st to 15th day of September and 1st to 15th day of March in respect of each financial year. **Kindly send your claim form at mstcmedicaltrust@mstcindia.co.in with a copy to hofin6@mstcindia.in**