Annexur

# Pos-Retirement Medical Expenses Claim-Cum-Voucher
# (DOMICILIARY TREATMENT)

For the Financial Year _____ to _____
Period (April-Sept.) / (Oct. – March)

Name : _____

Emp.No. : _____ Grade last held _____

Address : _____

_____

_____

PIN

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

Particulars of Beneficiaries for whom contribution has been paid :

1. a) Name of spouse _____
   b) Age _____
2. a) Name of father _____
   b) Age _____
3. a) Name of mother _____
   b) Age _____
4. a) Name of handicapped child _____
   b) Age _____

I certify that my expenditure on account of domiciliary treatment in respect of self and other beneficiaries mentioned above, who are wholly dependent and residing under the same roof with me for the period April-Sept. / Oct.-March in the Financial Year _____ has not been less than Rs. _____

(Amount in words : _____

In terms of provisions of the Post-Retirement Medical Scheme, the above expenses may please be reimbursed to me.

Date : Signature _____

FOR USE IN FINANCE DEPTT. TRANS. NO.

PASSED FOR PAYMENT OF RS. _____ RUPEES IN WORDS _____

_____

JAC/SEC ACTT. ACO / SACO