आज़ादी का अमृत महोत्सव

बड़ौदा यू.पी.बैंक
Baroda U.P. Bank

प्र.का. / 04 / बी.आर. / इन्श्योरेंस / 2023-24 / 156

दिनांक : 13.09.2023

बैंक की समस्त शाखाओं, कार्यालयों एवं सेवानिवृत कार्मिकों हेतु परिपत्र
प्रधान कार्यालय के इन्श्योरेंस विभाग द्वारा जारी

महोदय/ महोदया,

विषय : बैंक के सेवानिवृत्त कार्मिकों / पारिवारिक पेंशनर्स हेतु ग्रुप चिकित्सा बीमा पॉलिसी का दिनांक 01.09.2023 से 31.08.2024 की अवधि के लिए नवीनीकरण (नवीनीकृत पॉलिसी संख्या : 84000034230400000015).

कृपया बैंक के परिपत्र सं. प्र.का./04/बी.आर./इन्श्योरेंस/2023-24/137 दिनांक 17.08.2023 एवं प्र.का./04/बी.आर./इन्श्योरेंस/2023-24/144 दिनांक 24.08.2023 का सन्दर्भ ग्रहण करें जिसके माध्यम से बैंक के सेवानिवृत्त कार्मिकों हेतु ग्रुप चिकित्सा बीमा पॉलिसी के दिनांक 01.09.2023 से 31.08.2024 की अवधि के नवीनीकरण हेतु विस्तृत दिशा निर्देश निर्गत किये गए थे।

तत्क्रम में सूचित करना है कि बैंक द्वारा सेवानिवृत्त कार्मिकों / पारिवारिक पेंशनर्स हेतु ग्रुप चिकित्सा बीमा पॉलिसी का नवीनीकरण M/s The New India Assurance Co. Ltd. से दिनांक 01.09.2023 से 31.08.2024 की अवधि के लिए किया गया है।

नवीनीकृत पॉलिसी के विषय में निम्नवत अवगत कराया जाता है :

1. नवीनीकृत ग्रुप चिकित्सा बीमा पॉलिसी सं० 84000034230400000015 (संलग्न) के नियम व शर्तें दिनांक 31.08.2023 को समाप्त हुई पॉलिसी (प्र०का०/03/बी.आर/इन्श्योरेंस/2022-23/152 दिनांकित 02.09.2022) के समान ही रहेंगी।
2. पॉलिसी में बीमा कवर राशि प्रति सेवानिवृत्त अधिकारी/कर्मचारी निम्नवत है :

पद	बीमा कवर (रु.)
सेवानिवृत्त अधिकारी संवर्ग	4,00,000/-
सेवानिवृत्त कार्यालय सहायक / परिचारक (बहुउद्देशीय)	3,00,000/-

3. दावों के निपटान हेतु इस वर्ष के लिए भी M/s Health India Insurance TPA Services Private Ltd को बीमा कंपनी द्वारा थर्ड पार्टी एडमिनिस्ट्रेटर (TPA) नियुक्त किया गया है।
4. प्रतिपूर्ति दावा हेतु क्लेम फॉर्म का निर्धारित प्रारूप इस परिपत्र के साथ संलग्न है।
5. योजना से सम्बंधित परिचालानात्मक दिशा-निर्देश एवं कैशलेस एवं प्रतिपूर्ति दावों के निपटान सम्बंधित जानकारी एवं किसी भी समस्या के समाधान हेतु M/s Health India Insurance TPA Services Private Ltd एवं M/s K M Dastur Reinsurance Brokers Pvt Ltd के संपर्क नम्बर व Escalation matrix इस परिपत्र के साथ संलग्न है।
6. योजना में आच्छादित समस्त सेवानिवृत्त कार्मिक एवं पारिवारिक पेंशनर्स अपने e-कार्ड डाउनलोड, अस्पतालीकरण इलाज हेतु कैशलेस/प्रतिपूर्ति दावों के निपटान सम्बंधित जानकारी / प्रगति के लिए TPA के निम्न पोर्टल / मोबाईल ऐप पर लॉग-इन कर जानकारी प्राप्त कर सकते हैं:

https://www.healthindiatpa.com	TPA इन्टरनेट पेज/ पोर्टल
HEALTH INDIA INSURANCE TPA एप	Apple Store पर उपलब्ध & ANDROID फ़ोन पर उपलब्ध

7. M/s Health India Insurance TPA Services Private Ltd पोर्टल/एप पर अपनी प्रोफाइल पर लॉग-इन करने की विधि इस परिपत्र के साथ संलग्न है।
8. कैशलेस/प्रतिपूर्ति दावों के निपटान सम्बंधित जानकारी हेतु क्षेत्रीय कार्यालय उक्त TPA के एप HealthIndia HR Broker का सहयोग लें। उक्त एप का यूजर आई. डी. एवं पासवर्ड क्षेत्रीय कार्यालयों को पूर्व में प्रेषित किये जा चुके हैं।
9. कैशलेस इलाज हेतु नेटवर्क अस्पताल की सूची M/s Health India Insurance TPA Services Private Ltd की अधिकृत वेबसाइट (https://www.healthindiatpa.com) से प्राप्त की जा सकती है।
10. योजना के अंतर्गत प्रतिपूर्ति दावों का प्रेषण M/s Health India Insurance TPA Services Private Ltd को सम्बंधित क्षेत्रीय कार्यालय के माध्यम से किया जा सकेगा।

जारी.....02

प्रधान कार्यालय : बुद्ध विहार व्यावसायिक योजना, तारामंडल, गोरखपुर-273016, टेली. 0551-2230240
Head Office : Buddh Vihar Commercial Scheme, Taramandal, Gorakhpur - 273016, Tel. 0551-2230240
e-mail : ho@barodauprrb.co.in

11. TPA को प्रतिपूर्ति दावों या दावों के निपटान के संबंध में TPA द्वारा पूछे गए प्रश्नों (query) का उत्तर सीधे उनके निम्न पते पर भी प्रेषित कर सकते हैं। TPA को पत्राचार Registered A.D. (Acknowledgement Due) Post यथा पंजीकृत डाक पावती के माध्यम से ही प्रेषित कर रसीद भविष्य में संदर्भ हेतु सुरक्षित रखें :

The State Head
Health India Insurance TPA Services Pvt Ltd
C-69, Ground Floor
Near R K Timber, Vibhuti Khand
Gomti Nagar, Lucknow – 226 010
Phone : 0522 – 4590005
E-mail : tpalucknow@healthindiatpa.com

12. सेवानिवृत्त कार्मिकों को सलाह दी जाती है कि प्रतिपूर्ति दावों के प्रेषण से पूर्व दावा फॉर्म एवं समस्त प्रपत्र /diagnosis/रिपोर्ट एवं दावे से संबन्धित अन्य किसी भी प्रपत्र की मूल प्रति TPA को प्रेषित करने के साथ-साथ उसकी एक प्रति अपने पास सुरक्षित रखें जिससे कि भविष्य में दावे से संबन्धित किसी भी प्रश्न (query) का उत्तर TPA को दिया जा सके।
13. **दावों के निपटान में किसी भी प्रकार के विलम्ब से बचने के लिए कृपया ध्यानपूर्वक नोट करें कि "दावों को बिना किसी प्रश्न (query) के सरलता से निपटाने के उद्देश्य से पूर्ण दस्तावेजों की आवश्यकता पड़ती है। पूर्ण दस्तावेज़ रखने का उद्देश्य यह सिद्ध करना है कि दावा देय है या नहीं एवं यह पॉलिसी के किसी अपवाद के तहत नहीं आता है। अतः TPA द्वारा पूछे गए प्रश्न (query) के उत्तर एवं दावों के निस्तारण हेतु TPA द्वारा वांछित दस्तावेज़ अविलम्ब TPA को प्रेषित करना सुनिश्चित करें ताकि दावों का निस्तारण ससमय हो सके।"**
14. दिनांक 01.11.2022 से 31.10.2023 की अवधि में सेवानिवृत्त होने वाले समस्त कार्मिक नवीनीकृत पॉलिसी में pro-rata प्रीमियम दर से आच्छादित होने हेतु विकल्प पत्र दिनांक **15.10.2023** तक सम्बंधित क्षेत्रीय कार्यालय को प्रस्तुत करें एवं प्रीमियम राशि के बराबर धनराशि खाते में जमा रखें जिससे कि उनके खाते से प्रीमियम राशि को नामे करते हुए उन्हें दिनांक 01.11.2023 से बीमा कंपनी द्वारा कवरेज प्रदान किया जा सके।
15. विकल्प पत्र इस परिपत्र के साथ संलग्न है।

नवीनीकृत पॉलिसी में आच्छादित होने हेतु इच्छुक कार्मिकों (दिनांक 01.11.2022 से 31.10.2023 की अवधि में सेवानिवृत्त) के पेंशन खाते से बीमा प्रीमियम राशि नामे करने सम्बंधित विस्तृत दिशा-निर्देश क्षेत्रीय /प्रशासनिक कार्यालयों को पृथक रूप से प्रेषित किया जाएगा।

परिपत्र की विषयवस्तु समस्त शाखाओं, कार्यालयों एवं बैंक के समस्त सेवानिवृत्त कार्मिकों / पारिवारिक पेंशनर्स के संज्ञान में लायें।

भवदीय,

(कृष्ण कुमार कश्यप)
महाप्रबंधक

संलग्नक : उपरोक्तानुसार

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED (To be Filled in block letters)

The issue of this Form is not to be taken as an admission of liablity

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City: State:

Pin Code Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : : Yes No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admited:

b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time H H M H g) Date of Discharge: D D M M Y Y h) Time: H H : M H

I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No

ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs.

iii. Post-hospitalization expenses Rs. iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total Rs.

vii. Pre -hospitalization period: days viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs. iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- Claim form duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date D D M M Y Y Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm- format
I) If injury give cause	indicate cause of injury	Tick the right option
If Medico legal	indicate whether injury is medico legal	Tick Yes or No
Reported to Police	indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID:

c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time: HH MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of Delivery: DD MM YY ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
I. Primary Diagnosis			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: ☐ Yes ☐ No I. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: DD MM YY

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authrities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

MEDICAL INSURANCE SCHEME FOR RETIREES OF BARODA UP BANK- SCHEME GUIDELINES

POLICY COVERAGE DETAILS	
Policy Period:	01.09.2023 to 31.08.2024
Policy Type:	Group Medical Insurance Policy only for Retired Employees of the Bank
Family Definition:	Self (Retiree) + Spouse or Widow / widower of the Retired Employee
Coverage Type:	Family Floater
Sum Insured:	For Retired Clerical/Sub Staff - INR 3,00,000/- For Retired Officers – INR 4,00,000/-
Pre-existing Diseases:	Coverage from day 1
30 days Waiting Period:	Waived Off
Waiting Periods on Specific Diseases:	Waived Off
Hospital Room Rent:	Room and Boarding expenses as provided by the Hospital/Nursing Home not exceeding INR 5000 per day or the actual amount whichever is less.
ICU Rent:	Intensive Care Unit (ICU) expenses not exceeding INR 7500 per day or actual amount whichever is less.
Professional Charges:	Surgeon, team of surgeons, Assistant surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees covered up to Sum Insured
All other expenses:	No Limits for all other expenses including Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO charges, Anesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, OT consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, orthopaedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses,, infra cardiac valve replacements, vascular stents, any other valve replacement, laboratory/diagnostic tests, X-ray CT Scan, MRI, any other scan, scopies and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.
Cost of Donor:	Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.
Ambulance Charges:	Ambulance charges are payable up to INR 2500/- per trip to hospital and/or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to INR 750/- per Hospitalization. Ambulance charges actually incurred on transfer from one center to another center due to Non availability of medical services/ medical complication shall be payable in full.
Pre and Post Hospitalization Expenses:	Expenses related to the ailment for hospitalization will be covered 30 days prior to hospitalization and 90 days after discharge.
Alternative Treatment:	Alternative Treatments are forms of treatment other than treatment “Allopathy” or “modern medicine and includes Ayurveda, Unani, Siddha, Homeopathy and Naturopathy in the Indian Context, for Hospitalization only in a hospital registered by the Central / State authorities
Day Care Treatment:	Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments. This condition will also not apply in case of stay in hospital of less than a day provided – A) The treatment is undertaken under General or Local Anaesthesia in a hospital / day care Centre in less than a day because of technological advancement and Which would have otherwise required hospitalization of more than a day.

Congenital Anomalies:	Expenses for Treatment of Congenital Internal / External diseases, defects anomalies are covered under the policy
Psychiatric Ailment:	Expenses for treatment of psychiatric and psychosomatic diseases payable for hospitalization.
All Advanced Medical Treatment:	All new kinds of approved advanced medical procedures for e.g. laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care surgery.
Taxes and Other charges:	All Taxes, Surcharges, Service Charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable. Charges for diapers and sanitary pads are payable if necessary, as part of the treatment. Charges for Hiring a nurse / attendant during hospitalization will be payable only in case of recommendation from the treating doctor in case ICU / CCU or any other case where the patient is critical and requiring special care.
Genetic Disorder:	Treatment for Genetic disorder covered
Other Medical Treatment:	Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc. are covered under the scheme. Treatment for all neurological/ macular degenerative disorders
External and Durable Equipment:	Rental Charges for External and or durable Medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Bi-PAP, Infusion pump etc. will be covered under the scheme. However, purchase of the above equipment to be subsequently used at home in exceptional.
Ambulatory devices:	Walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including Glucose Test Strips)/ Nebulizer/ prosthetic devise/ Thermometer, alpha / water bed and similar related items etc., will be covered
Cost of Artificial Limb:	Covered
Physiotherapy Charges:	Physiotherapy charges shall be covered for the period specified by the Medical Practitioner.

Policy Exclusions	
1	Injury / disease directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not).
2	A) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident. B) Vaccination or inoculation. C) Change of life or cosmetic or aesthetic treatment of any description is not covered. D) Plastic surgery other than as may be necessitated due to an accident or as part of any illness.
3	Cost of spectacles and contact lenses, hearing aids. Other than Intra-Ocular Lenses and Cochlear Implant.
4	Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.
5	Convalescence, rest cure, Obesity treatment and its complications including morbid obesity, treatment relating disorders, Venereal disease, intentional self-injury and use of intoxication drugs / alcohol.

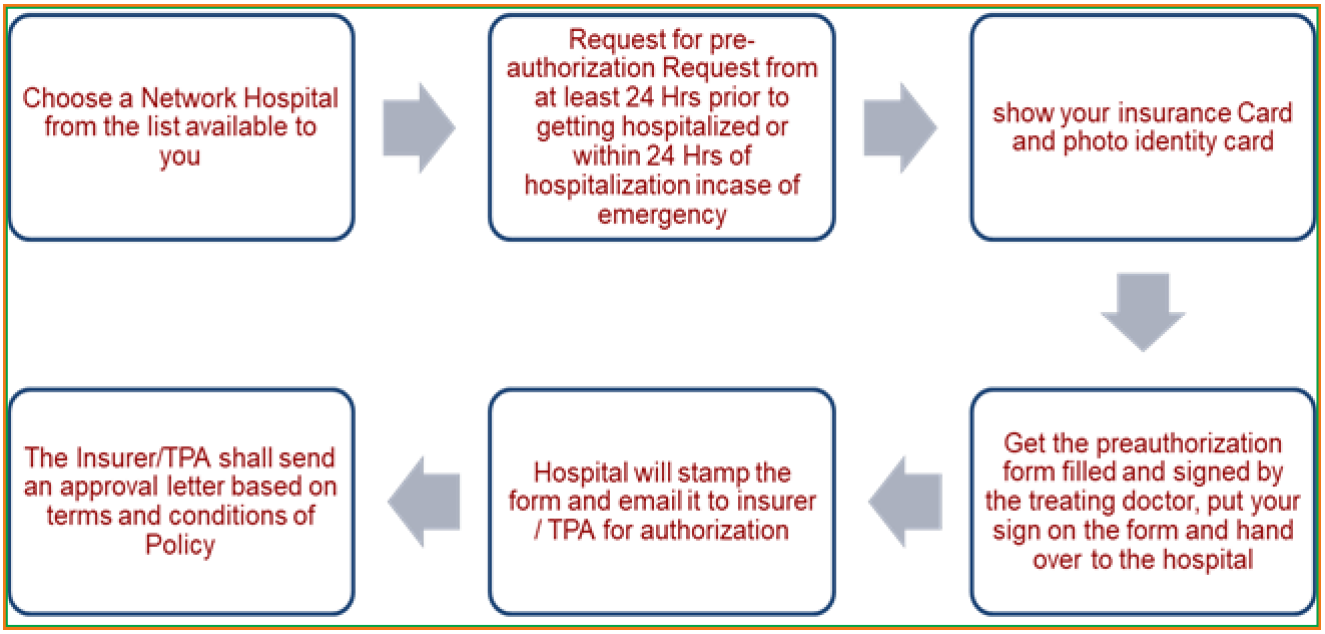
6	All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.
7	Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home, unless recommended by the attending doctor.
8	Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician.
9	Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials.
10.	All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, /barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses, unless and otherwise they are necessitated during the course of treatment.
11.	Attempted suicide, war, invasion, nuclear radiation is not covered.

OPERATIONAL GUIDELINES

HEALTH ID CARD	i. The scheme is being operationalized by The New India Assurance Company Limited and all the claims under the scheme are to be processed by the TPA. ii. Each retiree and their dependents will be issued separate TPA ID Card. iii. A network list mentioning the name of the Hospitals for cashless facility will also be circulated for ease of access of beneficiaries by the TPA. iv. **Log on to https://www.healthindiatpa.com/CustomerCorner/ECard.aspx**
IN-PATIENT HOSPITALIZATION CLAIM INTIMATION (HOSPITALIZATION IF AVAILED IN NON-NETWORK HOSPITALS)	v. The reimbursement claims are required to be intimated to the TPA within 24 hours of hospitalization and all original documents are to be submitted within 30 days of discharge from the hospital. vi. In case of planned hospitalization, the TPA is to be informed at least 2 days before the hospitalization, but in any emergency case within 24 hours of hospitalization. vii. Intimation has to be sent along with the following particulars: - a) Member ID/ PF ID No. b) Patient's Name c) Name and address of the hospital d) Disease / ailment and treatment given e) Date of Admission f) Requested amount (if any) viii. Intimation can be sent by the insured/ relatives/ Bank.
PROCEDURE & TIME SCHEDULE FOR SUBMISSION OF MEDICAL CLAIMS	All supporting documents in original, i.e. Discharge Card, Final bill with Break up, Money receipt, Prescription, Pharmacy Bills (GST bill), related Reports, X-rays, ECG strips, CT scan, MRI other documents relating to the claim must be submitted with the claim form within 30 days from the date of discharge from the hospital. In case of post-hospitalization treatment (limited to 90 days), all claim documents should be submitted within 30 days after completion of such treatment.

SUBMISSION & REIMBURSEMENT OF CLAIMS	♦ All claims are to be submitted on the prescribed format of the insurance company. Proforma of the claim form is enclosed. (A copy of filled claim form is also enclosed for example). ♦ Retirees shall lodge claim to the nearest Regional Office/Head office. ♦ Regional Offices and HRD Department will send the Claims to Head Office. Medical Support desk, HO will submit these bills to TPA on weekly, after keeping proper record.

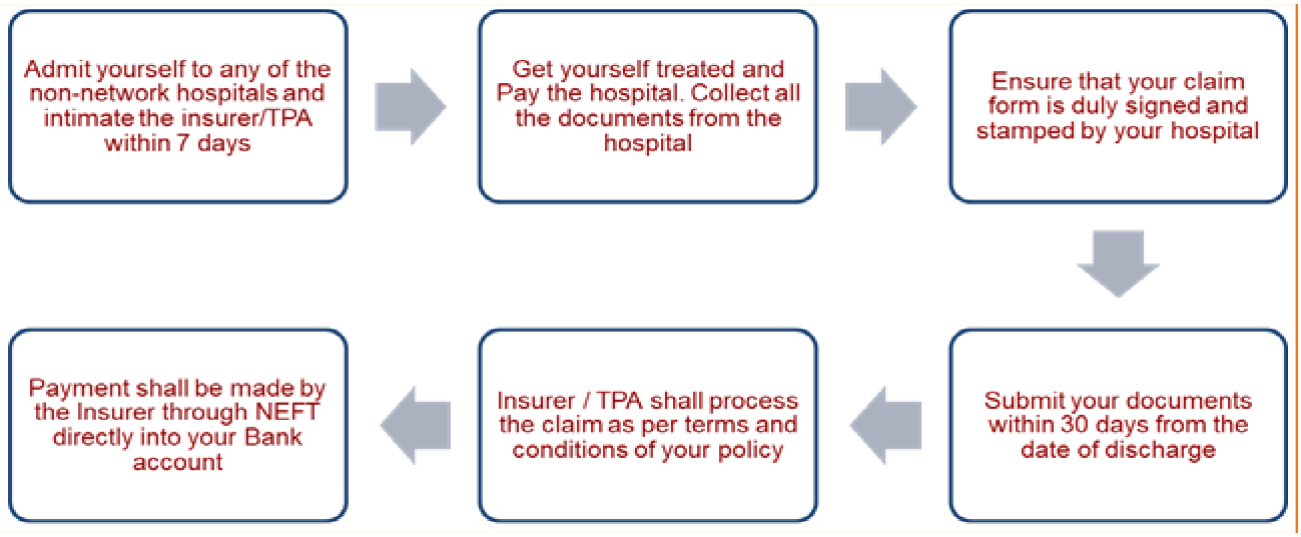
PROCEDURE FOR AVAILING CASHLESS



DOCUMENTS REQUIRED FOR AVAILING CASHLESS

Preauthorization form	Duly filled, signed & stamped Pre-Authorization Form from the hospital giving complete details of the ailment suffered the line of treatment and the estimated cost of treatment.
Investigation Reports	Investigation reports & previous consultation papers/ Admission advice (if any) prior to admission
Accident Claims	Copy of MLC/ FIR report in case of Road traffic accidents
Photo ID Proof	Photo ID proof such as Aadhar Card / PAN card / Passport / Driving License
Health Card	Copy of TPA Health ID card

PROCEDURE FOR REIMBURSEMENT



MANDATORY DOCUMENTS REQUIRED FOR REIMBURSEMENT CLAIMS

List of Mandatory Claims Documents-Reimbursement and Pre/post Claims

1. Duly signed claim form Part-A and Part-B (To be signed by Hospital)
2. Attested Photocopy of Hospital Registration Certificate - containing registration number, number of beds with and expiry date registration Certificate.
3. Claim intimation copy
4. Original discharge certificate
5. Original final bill with itemize bill breakup
6. Original money receipt
7. All original prescriptions.
8. All original investigation reports
9. Advice for admission/emergency consultation paper
10. Original pharmacy bill containing name of the patient, name of the consulting physician, name of the medicines and quantity along with batch no and expiry date and GST no of medicine shop.
11. Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/Mesh/IOL/Pacemaker.
12. Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA) and other medico legal cases.
13. KYC document: Photo Identity & Address Proof of Insured (E.g., Voter's Identity Card, Driving License, PAN Card, Passport, Aadhar Card).
14. NEFT details: Original cancelled cheque leaf of the employee and copy of front-page passbook

CLAIM INTIMATION DETAILS

E-mail for Claim Intimation Link: frd@healthindiatpa.com

Escalation Matrix- Health India Insurance TPA Services Pvt Ltd				
Escalation Level	**Process Owner**	**Designation**	**Contact Details**	**E-mail ID**
Level -1	SONU SINGH RAJPOOT	CRM Executive - Cashless	8707078737	tpalucknow@healthindiatpa.com
Level -2	VIVEK SINGH	Customer relationship manager	6394556605	tpalucknow@healthindiatpa.com
Level -3	Amit Gautam	Manager	9711048678	amit.gautam@healthindiatpa.com

Service Partners	K. M. Dastur Reinsurance Brokers Pvt. Ltd.
Zonal Office Address	4th floor, Suite No 6, 60B, Chowringhee Rd, Kolkata, West Bengal 700020

Escalation Matrix- K. M. Dastur Reinsurance Brokers Pvt. Ltd			
Escalation Level	**Process Owner**	**Contact Details**	**E-mail ID**
Level -1	Dr.Punnyashil Mukherjee	8240827394	p.mukherjee@kmdastur.com
Level -2	Md. Imran	9334330817	Md.Imran@kmdastur.com
Level -3	Dr. Joydip Mukherjee	9007112495	Joydip.mukherjee@kmdastur.com

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

POLICY SCHEDULE
NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY
UIN:NIAHLGP21281V022021

Insured Name	:	BARODA UP BANK

Insured's Details			Issuing Office Details		
Customer ID	:	PO82754462	**Office Code**	:	LUCKNOW_CBO (840000)
Address	:	BUDDH VIHAR, COMMERCIAL SCHEME, TARAMANDAL GORKHAPUR ,UTTAR PRADESH, 273016	**Address**	:	Arif Chamber-1, 3rd Floor Kapoorthala, Aliganj ,226020
Phone No	:	//	**Phone No**	:	05222329634
Fax	:		**Fax**	:	
E-mail/Fax	:	joydip.mukherjee@kmdastur.com, /	**E-mail/Fax**	:	nia.840000@newindia.co.in /
PAN No	:	AAAJB1748G	**S.Tax Regn. No**	:	AAACN4165CST178
GSTIN/UIN	:	09AAAJB1748G1ZF / NA	**GSTIN**	:	09AAACN4165C4ZM
	:		**SAC**	:	997133 (Accident and health insurance services)

Policy Details					
			Business Source Code		
Policy Number	:	84000034230400000015	**Dev.Off level./Broker / Direct/Corp. Agent/Web Aggregator/CPSC User**	:	K.M. Dastur Reinsurance Brokers Pvt. Ltd. - (DM2615660) K M Dastur 840000 - (SI00270648),
Period of Insurance	:	From:01/09/2023 12:00:01 AM To: 31/08/2024 11:59:59 PM	**Agent/Bancassurance/Specified Person**	:	
Date of Proposal	:	01/09/2023	**Phone No**	:	022 66179850, (022)22855855, 9769660727 / NA
Prev. Policy no.	:	NA	**E-mail/Fax**	:	jignesh.patel@kmdastur.com, sameer.mahyavanshi@kmdastur.com / /
Client Type	:	Corporate	**Financier(s) Details**	:	NA

Premium	GST	Total	Receipt No. & Date:
₹14672550	₹ 2,641,058	₹ 1,73,13,608 (RUPEES ONE CRORE SEVENTY-THREE LAC THIRTEEN THOUSAND SIX HUNDRED EIGHT ONLY)	84000081230000000485 06/09/2023

Details of TPA					
Name	:	HEALTHINDIA INSURANCE TPA SERVICES PRIVATE LIMITED	**Telephone**	:	02266867575
Address	:	NEELKANTH CORPORATE PARK, GALA NO : 406 TO 412 , 4TH FLOOR, KIROL ROAD / VILLAGE, VIDYAVIHAR SOCIETY,VIDYAVIHAR WEST, MUMBAI,MUMBAI	**Fax**	:	02242471911
		VIDYAVIHAR WEST, MUMBAI	**Email**	:	frd@healthindiatpa.com,
		MUMBAI	**Toll Free No**	:	NA

No. of Employees / Members covered	:	359			**No. of persons covered**	:	683
Maternity Benefits Opted	**Normal Delivery Limit ₹**	:	NA		**Zone Opted**	:	III (Rest of India)
	Caesarian Section Limit ₹	:	NA				
Deletion of 9 months waiting period		:	NO				
Pre-existing cover Opted		:	YES				
Deletion of 30 days waiting period		:	YES				
Deletion of 2/4 year exclusion		:	YES				
Limit of additional ambulance charges per person		:	0				

Signature Not Verified
Digitally signed by JAGAT JAYEE PANIGRAHI
Date: 2023.09.06 17:28:12 IST

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Additional cover Opted	:	NO

Special Conditions

Special Condition 1	:	AS PER TENDER DOCUMENT.
Special Condition 2	:	AS PER TENDER DOCUMENT.

* This Policy is subject to NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY Clause as attached
In the event of death of the insured person(s) due to an insured peril all benefits payable, in respect thereof under this insurance, shall become payable to the Nominee declared in the proposal (incoporated herein as the Schedule) and the Nominee declared in the proposal (incorporated herein as the schedule) and the receipt shall be construed as full and final discharge to the Company in respect of all liability under this policy.

Premium and GST Details

	Rate of Tax	Amount in INR
Premium		₹ 1,46,72,550
SGST	9	1320529
CGST	9	1320529
IGST	0	0

In witness whereof the undersigned being duly authorised by the Insurers and on behalf of the Insurers has (have) hereunder set his (their) hand(s) on this _____ day of _____20__.

For and on behalf of
The New India Assurance Company Limited

Date of Issue: 06/09/2023

Duly Constituted Attorney(s)

Mudrank_____Dt._____consolidated Stamp Fees Paid by Pay Order Number_____vide receipt number_____dt._____.

Stamp Duty under the Policy is ₹1/-.

PREMIUM CERTIFICATE FOR THE PURPOSE OF DEDUCTION UNDER SECTION 80 D OF INCOME TAX (AMENDMENT) ACT 1986

This is to certify that Mr./Mrs. BARODA UP BANK has paid ₹ RUPEES ONE CRORE FORTY-SIX LAC SEVENTY-TWO THOUSAND FIVE HUNDRED FIFTY ONLY (in words)
towards premium and GST of ₹2641058 for New India Flexi Floater Mediclaim for:

Policy period	:	01/09/2023 12:00:01 AM to 31/08/2024 11:59:59 PM
Policy Certificate no.	:	84000034230400000015
Reciept no. & date	:	84000081230000000485 and 06/09/2023

Date of Issue: 06/09/2023

IMPORTANT

This policy is subject to the terms and conditions contained in the policy document (Clauses).

This policy is governed by Health Insurance Regulations 2016 issued by Insurance Regulatory Development Authority of India on 12.07.2016.

This policy is also governed by IRDAI (Protection of Policyholders' Interest) Regulations, 2017.

This Schedule comes attached with the policy document (Clauses). If not attached, please ask for the same.

Health Insurance Regulation 2016 and IRDAI (Protection of Policyholders' Interest) Regulations, 2017 are available on the website of IRDAI.

Beware of spurious calls offering alluring benefits. Never share any policy details with unknown callers. Call 1800-209-1415 for any enquiry or contact the nearest operating office of New India Assurance Co Ltd.

IRDA Registration Number: 190
NIA PAN NUMBER: AAACN4165C

HealthieU

HEALTHINDIA ALLIED SERVICES PRIVATE LIMITED

2.3 ★
68 reviews

12 MB

3+
Rated for 3+

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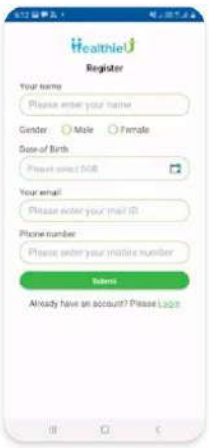
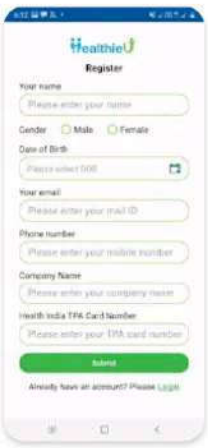
Install





About this app

HealthieU is a wellness company that aim to provide wellness services.

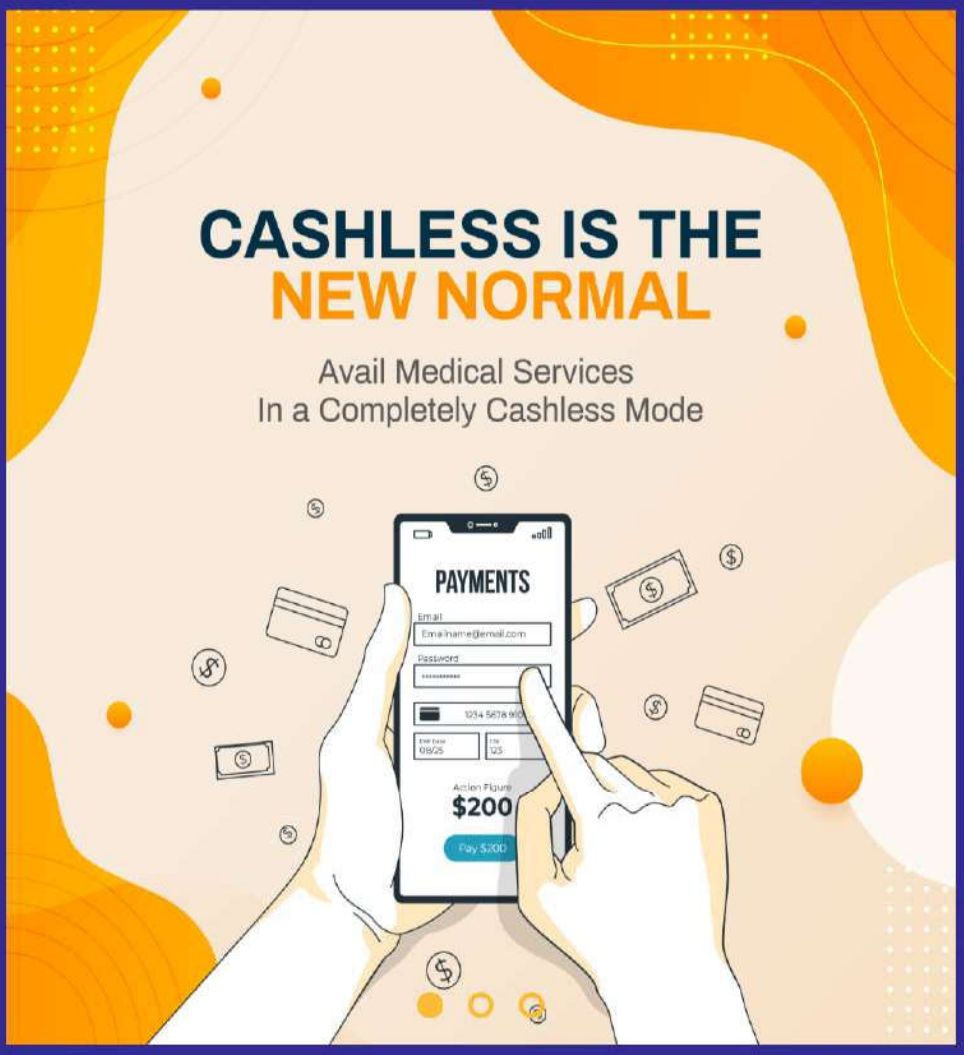
Business

Data safety

Developers can show information here about how their app collects and uses your data. Learn more about data safety

No information available

HealthieU



CORPORATE USERS

OTHER USERS

ENTER MOBILE NUMBER

LOGIN

Don't Have an Account ? **Register here**

HealthieU

REGISTER

Help

Your name *

Gender ○ Male ○ Female

Date of Birth *

Your email

Register contact number *

Employee Code *

Select your corporate name

☐ I accept Terms of Service, Disclaimer & privacy policy

SUBMIT

Mobile number not registered.

11:38 AM | 10.0KB/s

HealthieU

Welcome

NARENDRA NATH PANDEY

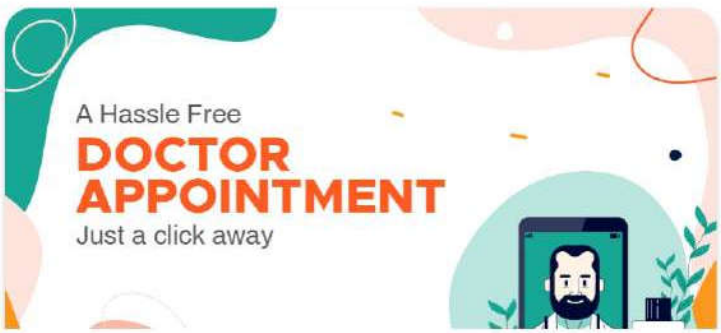
0	0 /900	0:0 Hr
STEPS COMPLETED	HEALTH SCORE	SLEEP COMPLETED

	Last Month	Last Week
	0	0
	0:0 Hr	0:0 Hr

AMBULANCE BOOKING

MENTAL WELLNESS

PHARMACY



HOME | FEATURES | CASHLESS OPD | INSURANCE

MY POLICY PROFILE

- POLICY DETAILS
- CLAIM DETAILS
- CLAIM INTIMATION
- SERVICE REQUEST
- FAMILY MEDICAL CARD
- LOCATE HOSPITAL
- HOSPITAL NEAR ME

बड़ौदा यू.पी.बैंक
Baroda U.P. Bank

Date: ……/…... /2023

The Regional Manager,
Baroda U. P. Bank,
Regional Office-……………...................
District-………………………......................

Dear Sir,

Re : Group Medical Insurance Scheme for Retired Officers/Employees.

I refer to your circular no. **HO/04/BR/Insurance/2023-24/137 dated 17.08.2023** on the captioned subject.

Tick

1.		Yes, I am willing to join Medical Insurance Scheme.
2.		No, I am not willing to join Medical Insurance Scheme.

If Yes:-

Details of Self (Officer/ Employee)				
Name				
Date of Birth	d d m m y y y y	Age		Years
Gender		Male		Female
Employee Code Number:				
Designation at the time of Retirement * (Tick before the option)		**Officer**	**If Yes than mention Scale at the time of Retirement**	
		Office Assistant (Multipurpose)		
		Office Attendant (Multipurpose)		
Retired from Region				
Details of Spouse (Dependent)				
Name				
Date of Birth	d d m m y y y y	Age		Years
Address for Correspondence				
	District		State	
Pin Code				
Mobile No.				
Email ID				
Pension Account number of BUPB for deduction of Premium& Reimbursement of claim				
	Branch-			

Please **Note:** *In absence of adequate funds in the account, if premium is not deducted and remitted to insurance Company, the insurance coverage for the said retiree shall stand discontinued. Therefore, it is desired that account of retiree is duly funded for deduction of the premium amount.*

Declaration-

- I…………………………………………………………(name of staff/ spouse) S/O or W/O……………………………. ……………………hereby declare that I have read & understood content of the circular no. **HO/04/BR/Insurance/2023-24/137** dated 17.08.2023 and accordingly submit the details of my dependent spouse as above.
- I declare that the above information is true to the best of my knowledge & belief and nothing material information has been concealed.
- I understand that the submission of false information to the Bank by me for gaining any monetary benefits I may be liable for appropriate action against me.
- I undertake that I will immediately inform to the bank in case of any change in the status of dependents as detailed above.
- I also undertake that for the payment of renewal premium. I irrevocably authorize the Bank to debit insurance premium amount from my aforementioned pension account number during current policy year and also in coming renewals.
- **In case, if my intention is not to renew the policy I will inform in writing at least one month in advance of the renewal date. I am aware that once I exit the scheme, I will not be allowed to rejoin it later.**

Declare and undertaken by:

Signature
Name: ……………………………………..
EC No: ……………………………………..
Retired from Region: ………………...
Designation at the time of retirement: …………………………..

……

(Certificate by the reporting authority)

- I hereby certify that the above information submitted by Mr/Ms. …………………………………….. (Retired staff name) EC No………………… or by spouse of the referred deceased / retired staff (Name……………………………………………………..) are true to the best of my knowledge and belief.
- The account provided above belongs to him/her and signature have been checked and verified from Branch Records.

Signature and Seal
Branch Manager, Branch-…………………………..
Region-……………………………………………………..

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(Forwarded with recommendation)

Regional Office: ………………………………...
Region :…………………………………
Seal : …………………………………