46/c

महानगर टेलीफोन निगम लिमिटेड, मुंबई

MAHANAGAR TELEPHONE NIGAM LIMITED, MUMBAI

(A Government of India Enterprises)

कार्यकारी निदेशक का कार्यालय, 9वीं मंजिल, टेलीफोन हाउस, एमटीएनएल मार्ग, दादर (प.), मुंबई–400 028
O/o Executive Director, Welfare Section, 9th Floor, Telephone House,
MTNL Marg, Dadar (W), Mumbai - 400 028. Ph: 24377676

WL/110-23/Retd. Empl/CGHIS/Enrollment/2022-23/ **DT.19/10/2022**

MOST URGENT TIME BOUND

To,

Retirees of MTNL Mumbai.

Sub: Submission of MTNL Retired employees CGHIS enrollment form for the policy period from 01.10.2022 to 30.09.2023 by 31/10/2022.

Ref: 1) MTNL/CO/Medical/Ret.Tender/CGHIS/2021/ Dtd.20/08/2022
2) WL/110-23/Retd.Emp/CGHIS/Enrollment /2022-23 DTD.02/09/2022

With reference to the subject cited above, submission of MTNL Retired employees CGHIS enrollment form for the policy period from 01.10.2022 to 30.09.2023 to be done by **31/10/2022.** Those retirees who have not submitted enrollment form till date are requested to submit **attached ANNEXURE A, B & F FORM through E-mail, at: mtnlpensionermedical@gmail.com,** alongwith Copy of **Pension Book (PPO) Page No.1, 6 & 8** wherein Name & Date of Birth of spouse is appeared and Copy of **Aadhaar Card** OR **PAN Card before 31/10/2022.**

In case, enrollment form is not submitted on or before 31/10/2022, it will be assumed that no medical facility from MTNL is required to those retirees. No application will be entertained after 31/10/2022.

Wide publicity may be given to this circular and circular may be pasted on Notice Board in the MTNL Building premises.

This issues with the approval of Competent Authority.

19.X.2022

Dy. General Manager (A&IR)
MTNL, Mumbai.

उप महाप्रबंधक (प्रशा. आर.)
DY. GENERAL MANAGER (A&IR)
महानगर टेलिफोन निगम लिमिटेड
Mahanagar Telephone Nigam Ltd., Mumbai

Copy to:

(1) **PGM (HR), C.O.**
(2) **SM to ED, MTNL, Mumbai: For infn. pl.**
(3) **SM (WFMS)**
(4) **All SM/DMs (Admin)/ SM/DM (BW)/ SM/DM (FC): For necessary action pl.**
(5) **DM (Cash/ Works) concerned: For deduction of Insurance Premium.**
(6) **General Secretary, MTNKS, Mumbai.**
(7) **Association and Union of Retired Executives & Non-Executives.**

ANNEXURE-A

MTNL RETIRED EMPLOYEES CONTRIBUTORY GROUP HEALTH INSURANCE SCHEME
APPLICATION FOR REGISTRATION & CLAIMS
(Tick mark whichever is applicable)

SM (Admn) _____
MTNL, Mumbai.

Sir,

1. I am Retired employee/ dependent of retired employee of MTNL and would like to join the Company's Retired Employees Contributory Group Health Insurance Scheme.

2. I request that medical coverage be extended to self and/or spouse as named below:-

Sl. No.	Name of beneficiaries	Relation	Date of Birth
1		Self	
2		Spouse	

1. Reimbursement of Indoor bills submitted from time to time may please be deposited in my Bank Account No._____ with _____ Bank. New Delhi/Mumbai as admitted/ through cheque drawn in my name.
2. I undertake to notify to the company any change in the above particulars as soon as it occurs.
3. I understand that the company reserves the right to refuse the membership to any retiree or terminate the same at any time, by giving one month's notice and specifying the reason thereof. Company's decision in this behalf shall be final.
4. I undertake to abide by the rules of this Scheme, as amended from time to time.

Yours faithfully,

Signature

Phone No. Resi. _____ Mobile: _____

Name _____

P.P.O. No._____, Staff No. (As per Salary Slip) _____

Designation _____ Scale of Pay _____ Basic Pay_____

Address for Correspondence _____

_____

Signature of the Applicant _____

ANNEXURE-B

MTNL RETIRED EMPLOYEES CONTRIBUTORY GROUP HEALTH INSURANCE SCHEME
INFORMATION FOR ISSUE OF MEDICAL CARD

1. Name of the Retired Employee _____
2. P.P.O. No._____, Staff No. (As per Salary Slip) _____
3. Date of Retirement _____
4. Designation _____
5. Scale of Pay _____ Basic Pay_____
6. GM Office _____
7. Permanent Address _____
   _____
8. Present Address _____
   _____
9. Validity from _____ to _____ (to be filed by issuing Authority)
10. Details on Medical Card.

Sl. No.	Name of beneficiaries	Relation	Date of Birth
1		Self	
2		Spouse	

NOTE:

1. Please note that Medical Claims are to be made in the prescribed form of the Company.
2. Separate claim should be preferred for each patient and each spell of treatment.

Signature of the beneficiary: _____

ANNEXURE-F

MTNL RETIRED EMPLOYEES CONTRIBUTORY GROUP HEALTH INSURANCE SCHEME

CERTIFICATION/DECLARATION

(Tick mark whichever is applicable)

1. Certified that I am not availing any other medical cover in consequent of employment of my Spouse, or any type of medical facility or allowance from any other source or CGHS facility.

2. Certified that my spouse is not employed.

3. Certified that my spouse Mr./Mrs. _____ _____ is employed with/ retired from _____ _____ and availing medical facility/ medical allowance from his/her employer. (A certificate of his/her employer to that effect is enclosed).

Date:

Place:

Signature:

Name:

Address:

Phone No:

Mobile No: