महानगर टेलीफोन निगम लिमिटेड, मुंबई

MAHANAGAR TELEPHONE NIGAM LIMITED, MUMBAI

(A Government of India Enterprises)

कार्यकारी निदेशक का कार्यालय, 12वीं मंजिल, टेलीफोन हाउस, एमटीएनएल मार्ग, दादर (प.), मुंबई–400 028

O/o Executive Director, Welfare Section, 12th Floor, Telephone House,
MTNL Marg, Dadar (W), Mumbai - 400 028.

WL/110-23/Retd. Empl/CGHIS/Enrollment/2022-23/ **DT.2/09/2022**

MOST URGENT
TIME BOUND

To,
All PGMs/ Sr. GMs,
All GMs/ CE(BW)/ All DGM (IFAs), MTNL, Mumbai

Sub: Contributory Group Health Insurance Scheme 2022 (CGHIS) for MTNL Retired Employees w.e.f. 01/10/2022.

Ref: MTNL/CO/Medical/Ret.Tender/CGHIS/2021 Dtd.20/08/2022

With reference to the subject cited above, in order to avail Contributory Group Health Insurance Scheme (CGHIS) facilities **by Employee Retired from MTNL or his/her spouse** through TPA for the policy year **2022-23 (01.10.2022 to 30.09.2023)** the following procedure is required to be followed:-

A) Retirees who are already enrolled for CGHIS in policy year 2021-22

The enclosed list of Contributory Group Health Insurance Scheme for MTNL Retired Employees for the policy year 2022-23 are already forwarded to Corporate Office for enrollment. They do not need to fill Annexure A,B&F form in policy year 2022-23.

B) Fresh Retirees/Retirees who have not enrolled for CGHIS in the policy year 2021-22

Please 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.**

1. The last date for submission of enrollment form is 15/09/2022. No E-mail enrollment form will be accepted thereafter in respect of the employees retired on or before 30.09.2022. If enrollment form not submitted before 15/09/2022, the retiree will not be eligible to avail CGHIS medical facility for the policy year 2022-23.

2. The CGHIS medical card will be issued to retiree without photo by post and for e-card please log on www.medsave.in.

3. In order to get break free medical coverage, retirees are advised to submit enrollment form before 15/09/2022.

4. Circulars regarding CGHIS available on **http://pensioner.mtnl.in** uploaded from time to time shall be binding to all retirees.

5. Concerned DM(Cash/works), MTNL Mumbai shall deduct the 50% of Insurance premium from OPD limit as & when instructions/orders received from C.O. MTNL, New Delhi. If CGHIS facility is not opted, then OPD reimbursement claim of retiree will not be allowed.

6. This CGHIS medical scheme is applicable to **MTNL Optee Retiree only.**

7. This CGHIS medical scheme is applicable to **Employee Retired from MTNL or his/her spouse only.**

8. The Employee Retired from MTNL or his/her spouse, those who have **got CGHS Card (Central Government Health Scheme), shall not be allowed to avail this CGHIS facility.**

9. All concerned SM/DM(Admn) shall guide the retirees for enrollment in CGHIS for the policy period 2022-23.

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.

Dipatkar 2/09/2022

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