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/2025-26 **DT.** 09 **/05/2025**

To,

TIME BOUND

Retirees of MTNL, Mumbai.

Sub: Contributory Group Health Insurance Policy for MTNL Retired Employees (CGHIS)

Ref: No.MTNL/CO/Medical/Retiree/Tender/ CGHIS 2024—136 dt. 04.03.2025

With reference to the subject cited above, concerned retirees **(those retirees who are not eligible for CGHS)** who wish to enroll in CGHIS are advised to submit the enrollment form **personally at Welfare Section, 12th Floor, Telephone House, Prabhadevi, Mumbai-400028 positively by 31.05.2025.**

In case, enrollment form is not submitted before 31/05/2025, it will be assumed that no medical facility from MTNL is required by those retirees.

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.

09/05/2025

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

Copy to:

(1) OSD to CGM, MTNL, Mumbai: For information. pl.
(2) All GMs/ CE(BW)/ MTNL, Mumbai
(3)General Secretary, MTNKS, Mumbai.
(4)Association and Union of Retired Executives & Non-Executives.

Note: Please note that this facility is not available for Govt. Pensioners and Prorata Pensioners

ANNEXURE-A

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

GM (Admn) HQ
MTNL DELHI/MUMBAI

Sir,

1. I am retired employee/dependent of retd. 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	Photograph
		Self		
		Spouse		

Note: Please enclose two passport size photographs of each member specified in above.

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. In 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.Res:_____Mobile _____
Name_____
P.C.No_____Staff. No. _____
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

(A)

1. Name of the Retired Employee _____
2. P.C. No_____Staff No._____
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 filled by Issuing Authority)
10. Details on Medical Card-

Sl. No.	Name of beneficiaries	Relation	Date of Birth	Photograph
		Self		
		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:

Annexure-G

Self Declaration Form for Availing MTNL CGHIS Facility

I Ms/Mrs./Mr. _____ retired from O/o _____ MTNL on _____. I , hereby, declare that (Tick the relevant):-

1. I am willing to avail Contributory Group Health Insurance Scheme (CGHIS) provided by MTNL for MTNL's retired employees from 01.03.2025.
2. I agree to deduct 50% of CGHIS premium from my OPD claim amount.
3. I am not willing to avail CGHS provided by MTNL for it's retired employees from 01.03.2025.
4. I am not availing CGHIS provided by MTNL for it's retired employees since _____.

My personal details are as follows:-

1. Name _____
2. CPF Number _____
3. Scale of Pay at the time of Retirement_____
4. Mobile Number _____
5. E-mail Id _____
6. Address for Correspondence _____

_____

Above details are correct and in case it is found at any stage some information is concealed by me or found false, MTNL management may take suitable disciplinary action against me as per MTNL rules.

Signature _____

Name _____