

NHPC RETIRED EMPLOYEES' HEALTH SCHEME

Application for Medical Card

Space for
affixing joint
Photograph of
Beneficiaries

1.	Name of the Retired/Deceased Employee & Employee No.	
2.	Date of Retirement/Death	
3.	Date of joining NHPC Cadre	
4.	Designation at the time of Retirement/Death	
5.	Leaving Service on superannuation/ VRS/ Death/ Permanent Disability/ Others to specify(please indicate specifically)	
6.	Scale of Pay & the Basic Pay on the date of retirement/Death	
7.	Department/Division with the name of the Project/ Unit/ Office from where retired/died.	
8.	Name of applicant and relationship with deceased employee	
9.	Permanent Address	
10.	Present Address	
11.	Project/ LO/ Corporate Office from where reimbursement is to be taken by the retired employee, his/ her spouse and spouse/ children of the deceased employee	
12.	Particulars of the Bank Draft	
	Bank Draft No & Date	
	Amount	
	Name of the Bank & Branch	
	MICR Code	
	IFSC Code	
	Permanent Account No.	
	Contact No.	
13.	Name of the Beneficiaries	Date of Birth of beneficiaries:
	(a)	(Retd. Employee):
	(b)	Spouse of Retired/deceased employee:
	(c)	Children of deceased employee
		(1)
		(2)
		Retired Employee:
14.	Specimen Signature of the Beneficiaries	Spouse of Retired/deceased employee
		Children of deceased employee
		(1)
		(2)

(An extra copy of joint photograph of beneficiaries is enclosed for affixing on Medical Card).

Certified :

- a. That I and other beneficiary am/are not re-employed on full time basis.
- b. That beneficiaries (in case of children of deceased employee) are/were wholly dependent upon the deceased employee, their income does not exceed Rs.6000/- per month, they have not attained the age of 25 in case of son and 30 years in case of daughter and are not married. The child/children named _____ is/are physically handicapped / mentally retarded.
- c. I and other beneficiary am/are am/are not availing any other medical cover in consequence of employment of my spouse and my spouse is not employed and is not entitled to any medical cover.
- d. I and other beneficiary am/are not receiving any medical assistance from any organization as dependent of my ward.
- e. I have already settled all my outstanding balances and accounts with the Company except.....
- f. The above information / particulars are true to the best of my knowledge and in case anything is found otherwise, I may be debarred from benefits of the Scheme.
- g. I undertake to notify immediately any change in the above to Retired Employees Health Scheme Cell including any reason due to which I am not eligible to continue to avail the benefits under the Scheme.

Date _____

(Signature of the applicant)

Verified and forwarded to Retired Employees Health Scheme Cell of the concerned Office/Unit. The above beneficiaries are eligible to the benefits under the Scheme with effect from Additional two joint photos of beneficiaries are also attached.

Signature of Head of Project / Unit / Office or
Controlling Officer not less than the rank of Senior Manager

Designation:.....

RETIRED EMPLOYEES HEALTH SCHEME CELL

Checked with reference to the rules and beneficiaries are entitled to the benefits under the Scheme with effect from

Signature

Designation.....