The West Bengal Power Development Corporation Limited

(A Government of West Bengal Enterprise)

CLAIM FORM

WBPDCL MEDICAL SCHEME FOR THE RETIRED EMPLOYEES 2018

To be filled by the Insured:

A. **NAME OF THE RETIRED EMPLOYEE/ WIDOW/ WIDOWER (IN BLOCK LETTERS)** _____

B **PPO No./ FAMILY PENSION NO./ Ex EMP NO.** _____

C **CORRESPONDENCE ADDRESS** _____

_____

D **MOBILE NO** _____ **E Mail ID** _____

E **NAME OF THE PATIENT** _____ **RELATIONSHIP** _____

BANK DETAILS

NAME IN THE BANK ACCOUNT:			
NAME OF THE BANK:		**BRANCH:**	
ACCOUNT NUMBER:		**IFSC CODE:**	

DETAILS OF EXPENSES CLAIMED

A	**HOSPITALIZATION PERIOD**	:	_____ TO _____
B	**ROOM RENT**	:	
C	**NURSING CHARGES**	:	
D	**SURGEON/ ANESTHETIST/ CONS. DOCTOR FEES**	:	
E	**INVESTIGATION CHARGES**	:	
F	**OT CHARGES/ BLOOD/ OXYGEN/ CONSUMABLE CHARGES**	:	
G	**MEDICINES**	:	
H	**OTHERS**	:	
TOTAL CLAIM AMOUNT		:	

I do hereby confirm that the information furnished above are true to the best of my knowledge and belief. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme or Insurance.

SIGNATURE OF THE RETIRED EMPLOYEE/ WIDOW/ WIDOWER _____

NAME OF THE RETIRED EMPLOYEE/ WIDOW/ WIDOWER (IN BLOCK LETTERS) _____

PPO No./ FAMILY PENSION No./ Ex EMP No. _____