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. PAN No.: _____

F. 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

NAME OF THE HOSPITAL: _____

ADDRESS: _____

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 AMOUNT		:	
Pre/ Post Hospitalization Period			
A.	CONS. DOCTOR FEES	:	
B.	INVESTIGATION CHARGES	:	
C.	MEDICINES	:	
TOTAL 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) _____

Documents to be submitted on submission of claim:

01. All original vouchers, money receipts and bills
02. Original Discharge Certificate
03. A cancelled cheque of above mentioned Bank.
04. Photocopy of Identity Proof (PAN Card/ Voter Card/ Aadhar Card) of either self or dependent as the case may be.
05. Photocopy of Identity card provided by M/s Paramount HealthCare Management Pvt Ltd.
06. Any additional documents as requested.