Bank A/C No. : _____

GAIL (INDIA) LIMITED

[Form for claiming reimbursement of Medical Expenses]

CPF No. : Name : Designation :

Grade : Department : Location :

System of Medicine : Allopathy ☐ Homeopathy ☐ Ayurvedic ☐ Unani ☐ Tibetian ☐

Patient's Detail

Patient S.No.	Name	Relation	Place of Treatment
1.			
2.			

Patient S.No.	Name	Relation	Place of Treatment
3.			
4.			

(A) Consultation Charges

Patient S.No.	Date	Name of Physician	Consultation No.	Outstation Treatment (Yes/ No)	Amount (Rs.)	
					Claimed	Passed
				Total (1) :		

(B) Medicines, Injections, Dressings & Other Charges

Patient S.No.	Date	Cash Memo No.	Particulars	Amount (Rs.)	
				Claimed	Passed
			Total (2) :		

(C) Pathological, Bacteriological and Radiological Tests etc.

Patient S.No.	Date	Cash Memo No.	Name of Clinic/ Lab	Particulars of tests	Recommended (Yes/ No)	Amount (Rs.)	
						Claimed	Passed
					Total (3) :		

(D) Hospitalisation Charges

Patient S.No.	Date		Name of the Hospital	Recommended (Yes/ No)	Amount (Rs.)	
	From	To			Claimed	Passed
				Total (4) :		

(E) Travel Expenses (for outstation treatment)*

Patient S.No.	Departure		Arrival		Travel Mode	Travel Fare (Rs.)		Local Conveyance Expenses (Rs.)		Remarks
	Date	Place/ Station	Date	Place/ Station		Claimed	Passed	Claimed	Passed	
					Total (5) :					

** : Please enclose a copy of the permission obtained for Outstation Medical Treatment*

Total Claim :

Total Amount Claimed **(1) to (5)**, Rs. :

Less Advance Taken (if any), Rs. :

Net Amount Claimed, Rs. :

Certified that :

a) My wife/ husband is not employed anywhere.

b) My wife/ husband for whom Medical reimbursement is claimed by me is employed in _____, which provide Medical facilities but she/he is not preferring any claim in this regard to her/his employer.

c) (i) My son** has neither started earning nor attained the age of 25 years.
(ii) My daughter** has neither started earning nor is married.
*** : no age limit prescribed in case of physically/ mentally challenged son and daughter till she gets married*

d) My parents are residing at _____.

e) My parent(s) is/are wholly dependent on me. The income of my parents from all sources is not more than Rs.6000/- per month.

f) My child/ children who are wholly dependent on me, is/ are residing in Hostels for pursuing studies.

Date : _____ **(Signature of Employee)**

For use in F&A Department

Bill No. : Date : Total Amount Passed, Rs. :

Advance taken, Rs. : Net Amount Payable, Rs. :

Mode of Payment : Bank ☐ Cash ☐ Salary ☐

Amount passed in words, Rs. _____ only

(Signature of Accountant)
Name : _____
Designation : _____
Date : _____

(Signature of F&A Executive)
Name : _____
Designation : _____
Date : _____

Annexure-III
(1/2)

Post-Retirement Medical Scheme (PRMS)

GAIL (India) LIMITED

{Form for Claiming Reimbursement of Medical Expenses under PRMS for Chronic Ailments}

Name _____

Designation at the time of Superannuation/Separation _____

Grade at the time of Superannuation/Separation _____

Place of Posting _____

System of Medicine: **Allopathy** ☐ **Homeopathy** ☐ **Ayurvedic** ☐ **Unani** ☐ **Tibetan** ☐
(Please tick whichever is applicable)

Patient's Detail

S. No.	Name	Relation	Place of Treatment
1.			
2.			
3.			
4.			

Brief Nature of Illness:

_____

_____

_____

(A) Consultation Charges

Patient S.No.	Date	Name of Physician	Consultation No.	Place of Treatment	Amount (Rs.)	
					Claimed	Passed
1.						
2.						
3.						
4.						
				Total (A) :		

(B) Medicines, Injections, Dressings & Other Charges

Patient S.No.	Date	Cash Memo No.	Particulars	Amount (Rs.)	
				Claimed	Passed
1.					
2.					
3.					
4.					
			Total (B) :		

Post-Retirement Medical Scheme (PRMS)

(C) Pathological, Bacteriological and Radiological Tests etc.

Patient S.No.	Date	Cash Memo No.	Name of Clinic / Lab	Particulars of tests	Recommended (Yes/ No)	Amount (Rs.)	
						Claimed	Passed
1.							
2.							
3.							
4.							
					Total (C) :		

Total Amount Claim/Passed :

Total Amount Claimed (A) to (C), Rs. _____

Net Amount Passed (A) to (C), Rs. _____

1. Certified that the expenses as mentioned above have been actually incurred by me.
2. I am enclosing duly signed copies of doctor's prescription and relevant medical reports.
3. In case of the claim being filed by me is found to be false/forged, GAIL has the right to reject the same apart from initiating any other action as deemed fit.

Date: _____ **(Signature of Member/Dependent)**

Location: _____ **Name:** _____

For use in F&A Department

Bill No. _____ **Date** _____ **Total Amount Passed, Rs.** _____

Amount passed in words, Rs. _____ **Only**

(Signature of Accountant) **(Signature of F&A Executive)**

Name: _____ **Name :** _____

Designation: _____ **Designation:** _____

Date: _____ **Date:** _____

****