

BHARAT SANCHAR NIGAM LTD.

**BSNL EMPLOYEES MEDICAL REIMBURSEMENT SCHEME
REGISTRATION FORM**

1. Name of Employee: _____ 2. Designation: _____
3. Place of posting: _____ 4. Staff No.: _____ 5. Basic Pay: _____
6. Telephone: (Office)----- (Residence) -----
7. Details of Family Members:

Sl. No.	Name	Date of Birth	Relationship with employee	Blood Group (If available)

8. Details of chronic disease, if any: a)-----
b)-----
c)-----
d)-----
9. Options for outdoor treatment (under BSNLMRS):-
(tick any one of i), ii) or iii))
i) Outdoor/Domiciliary treatment from RMPs: Reimbursement against vouchers (as per Para 2.1.0).
ii) Outdoor/Domiciliary treatment: Entitlement without voucher(as per para 2.1.1)
iii) Outdoor/Domiciliary treatment from P&T Dispensaries (as per Para 2.1.2)

Declaration:

I hereby declare that above mentioned members of my family are fully dependent on me i.e. their income from all sources does not exceed Rs. 1500/- per month. If the above information is found to be false at any time, company can take action against me as per rules or as deemed fit.

(Signature of Employee)

FOR OFFICE USE ONLY

REGISTRATION NO. ISSUED-----
CARD ISSUED : YES/NO on -----
(Date of issue)

Signature of Issuing Authority