BHARAT SANCHAR NIGAM LIMITED
(A GOVT. OF INDIA ENTERPRISE)
OFFICE OF THE CHIEF GENERAL MANAGER
WEST BENGAL TELECOM CIRCLE
TELEGRAPH CHECK OFFICE
33, B. B. D. BAG (SOUTH), KOLKATA – 700 001

OPTION FORM - I FOR NEW CASES

MEDICAL REIMBURSEMENT SCHEME (BSNLMRS)
(Ref : BSNL HQ Letter No. BSNL /ADMN/1 dated 28.02.2003)

(All columns must be filled in mandatorily except HRMS/Vendor Code, otherwise the Option will not be entertaine

1. Name of the Retired Employee / Beneficiary :
2. Designation :
3. HRMS / Vendor Code No. :
4. Date of Retirement / Death :
5. Last Basic Pay :
6. Pay of Scale :
7. Status (Please Tick) : Retired ☐ Beneficiary ☐
8. Option for Outdoor/Domiciliary Treatment (Tick any one)

a) Reimbursement against vouchers (Under Para 2.1.0) : ☐
b) Reimbursement without vouchers (Under Para 2.1.1) : ☐

9. Bank Details :a) Name of the Bank :
   b) Branch :
   c) Accounts Number :
   d) IFSC :
10. PAN No. :

I, do, hereby certify that I have gone through the Office Memorandum No. BSNL/Admn-I/15-22 dated 11.04.2017 regarding reconsideration of extension of without voucher facility to Retired Employees v reference to letter vide No. 7-8/2010/EF/Part/1 dated 05.09.2011 and am exercising my option after satisfy myself about various provisions under BSNLMRS and it may not be changed in the same financial year.

Enclo : Photo Copy of :-
a) Medical Registration Card.
b) Cancelled Cheque
c) PAN Card
d) Last Pay Slip & P.P.O. Book.

Signature of the Optee
Date :
Mob No. :
Address :

Signature of the Controlling Officer with Date

Signature of the Disbursing Officer with Date

BHARAT SANCHAR NIGAM LIMITED
(A GOVT. OF INDIA ENTERPRISE)
OFFICE OF THE CHIEF GENERAL MANAGER
WEST BENGAL TELECOM CIRCLE
TELEGRAPH CHECK OFFICE
33, B. B. D. BAG (SOUTH), KOLKATA – 700 001

OPTION FORM - II FOR CHANGE OF OPTION

MEDICAL REIMBURSEMENT SCHEME (BSNLMRS)
(Ref : BSNL HQ Letter No. BSNL /ADMN/1 dated 28.02.2003)

(All columns must be filled in mandatorily if HRMS/Vendor Code is available, otherwise the Option will not be entertained)

1. **Name of the Retired Employee / Beneficiary :**
2. **Designation :**
3. **HRMS / Vendor Code No. :**
4. **Date of Retirement / Death :**
5. **Last Basic Pay :**
6. **Pay of Scale :**
7. **Status (Please Tick) :** Retired ☐ Beneficiary ☐
8. **Option for Outdoor/Domiciliary Treatment (Tick any one)**

a) **Reimbursement against vouchers (Under Para 2.1.0) :** ☐
b) **Reimbursement without vouchers (Under Para 2.1.1) :** ☐

9. **Bank Details :** a) **Name of the Bank :**
   b) **Branch :**
   c) **Accounts Number :**
   d) **IFSC :**
10. **PAN No. :**

I, do, hereby certify that I have gone through the Office Memorandum No. BSNL/Admn-I/15- dated 11.04.2017 regarding reconsideration of extension of without voucher facility to Retired Employee reference to letter vide No. 7-8/2010/EF/Part/1 dated 05.09.2011 and am exercising my option after sati myself about various provisions under BSNLMRS and it may not be changed in the same financial year.

Enclo : Photo Copy of :-
a) Medical Registration Card.
b) PAN Card
c) 78.2 fixation copy in Duplicate

Signature of the Optee

Date :
Mob No. :
Address :

Signature of the Controlling Officer with Date

Signature of the Disbursing Officer with Date

DECLARATION

I do hereby declare that I, my spouse and my dependent members whose name(s) was/were included in the Medical Card issued to me vide Registration No. WBT/BSNLMRS/CTO/_____ Dated_____ for availing of medical facilities will continue to satisfy the eligibility conditions as per BSNLMRS extant Rule issued by the Corporate Office, BSNL, New Delhi vide Memo No. BSNL/Admn.I/I(P) dated 23.08.2006.

I also declare that the under mentioned names do not avail any kinds of medical benefits from anywhere other than BSNLMRS.

Sl. No.	Names	Date of Birth	Relationship

_____

(Signature)

Name of the Retired :
Official / Officer

Enclo: Photo copy of
BSNLMRS Regn. Card.

Designation :

Permanent Address :

Date :

Telephone No.

Mobile No.