ANNEXURE-VII

Membership No.: | | | | | | | | |

(To be allotted by CO: PAD)

UNION BANK OF INDIA RETIRED
EMPLOYEES' MEDICAL ASSISTANCE SCHEME (UBIREMAS)

MEMBERSHIP FORM

(To be submitted in duplicate through last Branch/Office worked)

Passport Size Photograph jointly with Spouse (if living) attested by Branch Manager/ Departmental Head, where last worked

To
The Dy/Asst. General Manager (HRM)
H.R.M.D.
Union Bank of India
239, Vidhan Bhavan Marg
Mumbai – 400 021.

Dear Sir,

*I retired/will retire/ from the Bank's service with effect from _________________.
*My spouse retired on _________________ and thereafter expired on _________________.

I desire to become a member of the Union Bank of India Retired Employees, Medical Assistance Scheme. I enclose Demand Draft/Local Cheque No._____________ Dated ____________ for Rs. ______________ favouring "Union Bank of India Retired Employees' Medical Assistance Scheme" payable at Mumbai towards non-refundable membership fees under the Scheme.

My necessary details are as under:

1. Name in full (Primary Member – i.e. staff member retired/expired after retirement) :
2. P.F. No. :
3. Date of Birth :
4. Date of retirement from Service :
5. Retired on superannuation or under VRS Scheme or voluntary retirement under OSR/Pension Scheme :
6. Designation at the time of retirement from service :
7. Branch/Office last worked :
8. Name of the spouse, if living (Secondary Member) :
9. Date of Birth of Spouse :
10 Permanent residential address after retirement :
11. Telephone No. with STD Code :

12. Date of Death of Employee (If employee already expired after retirement) Copy of Death Certificate to be enclosed :

13. Nearest Branch of Union Bank of India (Nominated Branch for future transactions under the scheme) :

14. Saving Bank A/c. No. with the Nominated Branch :

15. Past Major illness, if any
    – Self :
    – Spouse :

* Fill-in whichever is applicable

I have read the scheme and the rules there under. I and/or my spouse will abide by the rules made under the scheme as revised from
time to time.

I am not/ my spouse is not gainfully employed.

I hereby declare that information furnished above is true to the best of my knowledge and I shall give any other information as and when required by the Bank. Kindly enroll me and/or my spouse as member/s of the Family Unit for the subject scheme.

Place: Signature
Date : Name:

* Enclose an additional passport-size photograph for Membership Card

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(For use of Branch/Office last worked)

Verified and forwarded for consideration

Date: Branch Manager/
Departmental Head
(Signature with Seal)

ANNEXURE-VIII

UNION BANK OF INDIA RETIRED EMPLOYEES' MEDICAL ASSISTANCE SCHEME

APPLICATION FORM FOR REIMBURSEMENT

1.a)	Name of the Primary Member (Retired Employee)	:	
b)	Designation at the time of Retirement	:	
c)	Employee No.	:	
2.	Name of Secondary Member (Spouse)	:	
3.	Membership No. of Family Unit Under this Scheme	:	
4.	Nominated Branch	:	
5.	S.B. A/c. No. at Nominated Branch	:	
6.	Residential Address/ Telephone No.	:	
7.	Expenses incurred for whom, (Mention name and also mention whether Primary Member or Secondary Member)	:	
8.	Nature of Disease/Illness (Medical Certificate must be submitted showing definite full diagnosis and nature of ailment)	:	
9.	Nature of Operation (Major/Minor)	:	
10.	Duration of the Treatment a) In Hospital	:	From ____________ to ____________ No. Of Days ______________ Bed Charges _____________
	b) At home, after hospitalisation	:	From ____________ to ____________

11.	Details of Hospitalisation Expenses incurred: (Enclose original bills)		Amount incurred	For use at R.O. Amount Entitled 100 % or 75 % as applicable subject to ceiling
	a) Registration Charges	:	________________	__________________
	b) Conveyance/Ambulance Charges	:	________________	__________________
	c) Operation Charges		________________	__________________
	d) Operation Theatre Charges	:	________________	__________________
	e) Anaesthesia Charges	:	________________	__________________
	f) Pathology Charges	:	________________	__________________
	g) Doctor's visit/consultations	:	________________	__________________
	h) Physiotherapy Charges	:	________________	__________________
	i) Drugs & Medicines	:	________________	__________________
	j) Blood Transfusion Charges	:	________________	__________________
	k) Surcharge on Hospital Bills	:	________________	__________________
	l) Other Charges	:	________________	__________________
		:	_____________	_______________
	Sub Total			
	Add: Bed Charges	:	________________	_________________
			==========	============
	Total Amount Eligible	:		
12.	Amount of Reimbursement towards hospitalisation expenses already received so far under the scheme, if any, for the Family Unit i.e. for self and spouse *	:		
13.	Whether holding any Medi-Claim Policy in the name of self or spouse	:		
14.	If so, amount of claim settled by the Insurance Company, out of the total expenses reported under Column No.11 (Enclose copy of the certificate/ sanction letter of the Insurance Company)	:		
15.	Balance amount not settled by the Insurance Company (Total of Column No.11 less amount shown in Column No.14)			
16.	Amount of Reimbursement requested			

* N.B. The total reimbursement including present bill should not exceed maximum limit of Rs.75,000/- throughout currency of Membership.

I certify the correctness of information given herein above. All Bills/ Certificates/Vouchers/Cash Memos in respect of expenses incurred as reported in Column No.11 & 14 are enclosed.

Place: Signature of the Primary/Secondary Member

Date: Name:

ANNXURE XXXII

APPLICATION FOR REIMBURSEMENT OF EXPENSES INCURRED FOR DIAGNOSTIC TESTS UNDER UBIREMAS.

1.	Name of the Primary / Secondary Member	:	
2.	Designation at the time of Retirement	:	
3.	Employee Number	:	
4.	Membership Number of Family Unit	:	
5.	Nominated branch	:	
6.	S.B. Account Number at nominated branch	:	
7.	Expenses incurred on whom (Mention name and also mention whether Primary Member or Secondary Member)	:	
8.	Nature of Diagnostic Tests undergone with amount incurred ECG, Stress Test, X-ray, City Scan, MRI Scan, ESR, Urine Test, Hematology, Blood Sugar, Blood Cholestrol, CBC, Lipid Profile, Serum Triglyceride, SGOT, SPOT, LDH, any other test (indicate the nature of test)	:	**Amount (in Rs.)** ....
9.	Name of Diagnostic Centre Details of Bill for which reimbursement is sought for	:	 **Bill No.: Dt: Amount: Rs.**
10.	Amount of reimbursement towards Diagnostic Expenses already received under the scheme during the financial year _________ for self / spouse (the amount should not exceed Rs.1,000/- for financial year or during the currency of membership	:	**For self Rs.** **For Spouse Rs.** _____________ **Total Rs.** ==========
11.	Amount of reimbursement requested	:	**Rs.**

I certify the correctness of information given herein above. All Bills/Certificates/Vouchers/Cash Memos in respect of expenses incurred as reported in Column No. 9 & 14 are enclosed.

Place:

Signature of the
Primary/Secondary Member

Date:

APPROVED / DECLINED

Sanctioned Rs. _______________ to Shri / Smt. _______________________, Membership No. ________________ under UBIREMAS which may be credit to his/her S.B. A/c. No. _________________ with _______________________ Branch (Nominated Branch)

REGIONAL HEAD
REGIONAL OFFICE, ______________