

CONSENT FOR PAYMENT OF MEDICAL INSURANCE PREMIUM (one month pro-rata) BY EX-STAFF MEMBERS WHO HAVE RETIRED/VRS/RETIRING DURING THE PERIOD 01.10.2021 TO 30.09.2022

To,
BRANCH MANAGER

_____ Branch.

Dear Sir,

REG: GROUP MEDICAL INSURANCE COVERAGE- PAYMENT FOR ONE MONTH PRO-RATA PREMIUM

I _____ Employee No _____ retired/ retiring from the services of the Bank on _____ (date of retirement) in Officer/ Clerical/ Sub-staff Cadre, express my willingness for payment of pro-rata premium for Insurance coverage for the month of October 2022 under the following option:

(TICK THE REQUIRED OPTION) – ANY ONE

OPTION	OFFICER	AWARD STAFF
OPTION I (A) SINGLE (Without Domiciliary cover)	Pro- rata premium Rs. 2387/-	Pro- rata premium Rs. 1870/-
OPTION I (B) FAMILY (Without Domiciliary cover)	Pro- rata premium Rs. 3673/-	Pro- rata premium Rs. 2878/-
OPTION II (A) SINGLE (With Domiciliary cover)	Pro- rata premium Rs. 4750/-	Pro- rata premium Rs. 3594/-
OPTION II (B) FAMILY (With Domiciliary cover)	Pro- rata premium Rs. 7308/-	Pro- rata premium Rs. 5529/-

Mandatory Details to be filled in:

Name of Retiree & spouse	Date of Birth	Age	Mobile No	Aadhar No.

Address: _____

Nominee Name: _____ AGE: _____ RELATIONSHIP: _____

I, HEREBY AUTHORISE THE BANK TO DEBIT Rs. _____ FROM MY ACCOUNT NO _____ WITH _____ BRANCH, FOR PRO-RATA PREMIUM AS TICKED ABOVE.

Yours Faithfully,

Place _____

Date: _____

Signature _____