THE MERCHANT NAVY OFFICERS' WELFARE FUND

Registered under Bombay Public Trust Act No. E-4771 of 1972 (Bom.)

"Udyog Bhavan", 4th Floor, 29 Walchand Hirachand Marg, Ballard Estate, Mumbai - 400 001.
Tel No. (91-22) 49680968 Mobile: 8828326202 **Email : mail@mnowf.com**

DOMICILIARY TREATMENT REIMBURSEMENT FORM

For Office Use Only

Inward Date : _______________ Inw No. ___________ By : ___________ | Claim No. ______________

IN CAPITAL LETTERS : **Plese fill the Form correctly after reading the instruction. (Refer overleaf)**

(A) Officers' Name : ____Rank : ____________________

Name of Company : ____Initial Date of Joining : _________________

Are you a permanent employee of the Company? (Yes/ No) _______Are you on Short Term Contract? (Yes/ No) _______

Is your Company remitting donation to the MNOWF Corpus on your behalf? (Yes/ No) __________________________

Are you a member of Company's Provident Fund? (If yes) Provdient Fund Account No. __________________________

Ship's Name and Date of Signed Off: ____

(Attach photo copy of relevat page of CDC for audit prupose)

Your MUI Membership No. (If any) ______________on Authorised Leave from : _______________to _______________

(B) Name of the Patient: ____ Date of Birth: _________________

Relationship: ______________ Nature of Illness: ____

Is the depenent Patient employed? (If yes) ____________Name of the Employer: ______________________________

(C) (Officers' Bank Details):

IFSC CODE : ☐☐☐☐☐☐☐☐☐☐☐

Name of the A/c Holder: _____________________________________

Name of the Bank: ____________________________A/c No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of the Branch: ____ Bank Address: ________________________

____Permanent Residence Address: ___________________________

____Pin Code: _______________________

Email: ___________________________________ Tel No_____________________Mob No. _______________________

(D)	Amount Claimed	Amount Admissible	Remarks
1. Consultation Charges :			
2. Visit No(s). ___________ Rate: _________:			
3. Medicines: Given by Doctor :			
Purchase from Outside :			
4. Investigations ________________________ :			
(E) DENTAL			
1. Consultation Charges :			
2. Extraction No. _______ Rs. ____________:			
3. Filling, Partial Denture or Treatment of any other nature :			
4. X-ray :			
5. Full Denture :			
Total :			

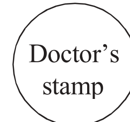
(F) **(To be completed by the Attending Doctor)**

Diagnosis : __________________________________ Duration of Illness From ___________ to __________

Date : _________________ Signature: ________________________

Name of Doctor and Registration No.

____



I hereby declare that the above statement is true to the best of my knowledge and belief.

Date: _______________ Signature: ______________________(Officer/Wife)

For Office Use Only.

Payment Details

Amount Paid : Checked By: 1. __________________ Trustee: 1. __________________

Cheque No.:

Date : 2.___________________ 2. ___________________

Prepared By :

(PTO))

Instructions to be followed:

1. Please attached Original Receipts for Consultation, Investigation and Medicines and also Prescription, Investigation reports to enable us to expedite settlement of claim(s). (refer Section “D” & “E”).
2. Please ensure that Section “F” is certified / stamped / signed by Medical Practitioner to avoid delay.
3. No claim below Rs. 1000/- will be entertained.
4. Claim Form should be submitted within 90 days after completion of treatment.
5. Separate Claim Form should be submitted for each illness.
6. Officers are requested to submit photo copy of Leave Sanctioned Form, current year Provident Fund statement and relevant page of CDC of last Vessel sign off while filling of Claim Forms.
7. The officer must ensure that Claim Form should be signed either by the Officer or in his absence by his wife.
8. Verification by the Doctor giving the diagnosis and period of treatment is a MUST for audit purpose.
9. Please intimate if you are receiving medical financial benefits for self and family from any other source(s). Please give details.
10. Officer’s children up to the age of 25 years are entitled for the Medical reimbursement benefits, subject to the condition that they are unmarried, unemployed and are solely dependent on Officer.
11. Parents, Brothers, Sisters and Relatives of Officer are not eligible for the Medical benefits.
12. Reimbursement of medical expenses will be processed exclusively through NEFT/RTGS. Please ensure that you submit accurate details of your savings bank account along with a copy of the cheque.
13. Additional information pertaining to your Medical Claims may be furnish in a separate sheet or to be mentioned in covering letter for sake of clarification.
14. Medical Reimbursement Forms (Hospitalisation Treatment or Domiciliary Treatment) can be obtained from the Funds office on request or you can download Claim Forms from **Website: www.mnowf.com**
15. All correspondence relating to Medical claims should be sent directly to **“The Merchant Navy Officers’ Welfare Fund”, Udyog Bhavan, 4th Floor, 29 Walchand Hirachand Marg, Ballard Estate, Mumbai - 400 001.**

THIS CERTIFICATE TO BE SIGNED BY OFFICER OR HIS WIFE IN CLAIMS OF THEIR CHILDREN

Certify that my son / daughter ____

age ________________is unmarried, unemployed and solely dependent on me.

Date : __________________ Signature __________________

(Officer / Wife)