



# 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) 22619321 Fax : (91-22) 22644670 **Email : mail@mnowf.com**

## DOMICILIARY TREATMENT REIMBURSEMENT FORM

### For Office Use Only

Inward Date : \_\_\_\_\_ Inw No. \_\_\_\_\_ By : \_\_\_\_\_ Claim No. \_\_\_\_\_

IN CAPITAL LETTERS : **Plse 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) Provident Fund Account No. \_\_\_\_\_

Ship's Name and Date of Signed Off: \_\_\_\_\_

(Attach photo copy of relevant page of CDC for audit purpose)

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 dependent Patient employed? (If yes) \_\_\_\_\_ Name of the Employer: \_\_\_\_\_

(C) (Officers' Bank Details):

Name of the A/c Holder: \_\_\_\_\_ IFSC CODE :

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 made by Cheque only. Please ensure to submit correct details of your Bank Account.
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](http://www.mnowf.com)**
15. All correspondence relating to Medical claims should be sent directly to **“The Merchant Navy Officers’ Welfare Fund”, Udyog Bhavan, 4<sup>th</sup> 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)