

Indian Officers Working on INSA / MUI Agreement
THE MERCHANT NAVY OFFICER'S WELFARE FUND

MEDICAL SCHEME

<p style="text-align: center;">M.N.O.W.F.</p> <p>Received on _____</p> <p>Date _____</p> <p>Inw _____ By _____</p>	<p>“UDYOG BHAVAN”, 4th Floor, 29, Walchand Hirachand Marg, Ballard Estate, Mumbai – 400 038.</p> <p>CLAIM FOR DOMICILIARY TREATMENT</p>	<p>For Office Use</p> <p>Claim No. _____</p>
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PARTICULARS OF CLAIM (IN CAPITAL LETTERS)	PARTICULARS OF OFFICER
Name of the Patient _____	Name _____
Date of Birth _____ Relationship _____	Company _____ Rank _____
Nature of illness _____	Whether on Contract or MUI Terms _____
Is the dependent patient employed ? YES/NO	Date of Joining _____
Name of Employer _____	Authorised Leave form _____ to _____
_____	Unemployed Since _____

Home Address _____

Particulars of Bank A/C

Name of A/c holder _____ Account No. _____

Name of the Bank _____

Name of the Branch _____ Address _____

1. Consultation Charges
No. _____ Rate _____
2. Visit Fees No. _____ Rate _____
3. Medicines given by Doctor _____
4. Medicines purchased from outside
INVESTIGATION _____

DENTAL :

- A Extraction No. _____ @ Rs. _____
- B Filling, partial denture or treatment of any other nature _____
- C Consultation _____
- D Xray _____
- E Full Dentures _____

(Must be completed by the attending Doctor)

Diagnosis _____

DURATION of illness from _____ TO _____

Date _____ Signature _____
(Name, Address, Qualification of attending Doctor)

Regn. No. _____ (Please use rubber stamp)

NOTE : Verifying Doctors' responsibility rests with diagnosis and period of treatment only

PLEASE SEE INSTRUCTIONS & CERTIFICATE ON THE REVERSE

I hereby declare that the foregoing statement are true in every respect and are made without any reservation, I also declare that I have not got nor I am likely to get any Medical help for the above illness for any other source.

Date _____ Signature of Officer/Wife _____

Amount Claimed	Amount Admissible	REMARKS
NET AMOUNT PAYABLE-Rs.		
FOR OFFICE USE ONLY		
1) _____		
2) _____		
Trustees	Secretary	

IMPORTANT

- (1) (Item 2) means visit by the doctor to the patient's residence.
- (2) Diagnosis and period of treatment must be verified by the attending physician, Dentist or Specialist who should sign the claim form without which it will be treated as invalid.
- (3) Amount shown against each item No. 1 to 4 in the claim form must be supported by separate receipts, vouchers, cash memos and must be attached along with the claim form.
- (4) The doctors' receipts should give complete details (i.e.) dates, visits/consultations and Particulars of injections and medicines and charges made thereof.
- (5) Claim form completed in all respects should be sent as early as possible.
- (6) Separate claim form should be submitted for each illness.

CERTIFICATE TO BE SIGNED IN CLAIMS OF CHILDREN

Certified that my son/daughter _____
age _____ is unmarried, unemployed and solely dependent on me.

Date :

OFFICER / WIFE