

Government of India
Ministry of Communication
Department of Telecommunications
Office of the Controller of Communication Accounts, Kerala
Door Sanchar Bhavan, Thiruvananthapuram.

No. CCA/KRL/Gen/FMA/2021.22

Date 02.02.2022

To,
The CGM,
BSNL, Kerala Circle, Trivandrum.

Sub:-Grant of Fixed Medical Allowance to BSNL Pensioners residing in areas not covered under CGHS-reg.

Ref:-DOT Hqrs Letter No. 47-14/CPMS/TA-II/2018/4696-4726 dated 21.10.2019.

It is to bring to your kind notice that vide letter referred above, DOT Hqrs has clarified on applicability of Fixed Medical Allowance to IDA pensioners (BSNL absorbed) residing in areas not covered under CGHS.

2. In view of the above, the following guidelines may be followed by all BAs of Kerala Circle for easy and faster processing of requests of Fixed Medical Allowance of IDA pensioners residing in areas not covered under CGHS :

(a) Pensioners who want to avail the Fixed Medical Allowance will submit their request along with the following documents to their respective BA from where they have retired.

- (i) An undertaking in prescribed proforma (proforma attached as Annexure 1)
- (ii) Application for availing Medical Facilities under Fixed Medical Allowance (format attached as annexure.2).
- (iii) Surrender Certificate of Medical Facility provided by the BSNL.
- (iv) Copy of CGHS card, if pensioner having CGHS facility

(b) On receipt of request from pensioners, the concerned BA shall verify and forward the same to this office for further action.

3. Alternatively, pensioners can also directly send the above mentioned documents directly to Accounts Officer (Pension), O/o the CCA, Kerala Circle for processing.
4. It is requested to circulate these guidelines to all BAs for necessary action.

(This is issued with the approval of CCA Kerala).

Encl:- As above.

R. Sathish Kumar
Joint Controller of Communication Accounts.
O/o CCA, Kerala Circle, Trivandrum-33

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UNDERTAKING

I..... a retired employee of
..... (office Address).....declare
that I am residing at(Residential Address indicated in PPO)
....., which area is not covered under CGHS or any
corresponding Health Scheme administered by the Ministry/Department of
.....(as the case may be). I Have also not obtained CGHS card/I have
obtained CGHS card and using it for availing IPD treatment only under CGHS (Tick
as applicable). I am also not member of corresponding health scheme of other
Ministry/Department from any dispensary located in an adjoining area.

Date:

(Signature of pensioners)

Place:

(Name of Pensioner)

PPO Number:

Form for availing Medical Facilities under central Government Health Scheme or Fixed Medical Allowance after retirement.

| | | | |
|--|--|-----------------|--|
| 1. I reside/will be residing at the following address: | | | |
| Flat/House No/Bldg. | | Street/Locality | |
| Name | | | |
| Village & Post | | City & District | |
| Office/ Block | | | |
| State | | Pin Code | |

2. I opt the following facility

(Please tick any one of the following)

| | |
|---|--------------------------|
| i. I will be residing in a CGHS area and would be availing CGHS facility | <input type="checkbox"/> |
| ii. I will be residing in a CGHS area but would not be availing CGHS facility. I understand that I will not be eligible for Fixed Medical Allowance (FMA) | <input type="checkbox"/> |
| iii. I will be residing in non-CGHS area but would be availing CGHS facility for In-patient Department (IPD) and Out-patient Department (OPD) treatment. I will not be eligible for FMA | <input type="checkbox"/> |
| iv. I will be residing in a non-CGHS area but would be availing CGHS facility for IPD treatment only by payment of CGHS contributions. I will also avail FMA for OPD treatment | <input type="checkbox"/> |
| v. I will be residing in a non-CGHS area and would not be availing CGHS facility for both IPD treatment and OPD treatment. I will avail FMA. | <input type="checkbox"/> |
| vi. I will avail medical facilities available to spouse/family members who is an employees/pensioner of Government/PSU/Autonomous Body. I will not avail CGHS facility and FMA | <input type="checkbox"/> |
| vii. Avail medical facility of previous organization. I will not avail CGHS facility and FMA | <input type="checkbox"/> |

This is my one time change in option as provided in the Rules and it supersedes the earlier option given by me. I understand that I shall not be able to change this option again (Strike out this item if not applicable)

| | | | |
|--|--|------------|--|
| Name of the retiring employee/ pensioner: | | Mobile No. | |
|--|--|------------|--|

(Signature of head of office)

(Signature of applicant)