Domiciliary Hospitalization / Domiciliary Treatment

Sr. No.	Treatments
1	Cancer
2	Leukemia
3	Thalassemia
4	Tuberculosis
5	Paralysis
6	Cardiac Ailments
7	Pleurisy
8	Leprosy
9	Kidney Ailment
10	All Seizure disorders
11	Parkinson's diseases
12	Psychiatric disorder including schizophrenia and psychotherapy
13	Diabetes and its complications
14	Hypertension
15	Hepatitis –B
16	Hepatitis - C
17	Hemophilia
18	Myasthenia gravis
19	Wilson's disease
20	Ulcerative Colitis
21	Epidermolysis bullosa
22	Venous Thrombosis(not caused by smoking) Aplastic Anaemia
23	Psoriasis
24	Third Degree burns
25	Arthritis
26	Hypothyroidism
27	Hyperthyroidism expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukemia
28	Glaucoma
29	Tumor
30	Diptheria
31	Malaria
32	Non-Alcoholic Cirrhosis of Liver
33	Purpura
34	Typhoid
35	Accidents of Serious Nature
36	Cerebral Palsy
37	Polio
38	All Strokes Leading to Paralysis
39	Haemorrhages caused by accidents
40	All animal/reptile/insect bite or sting
41	Chronic pancreatitis
42	Immuno suppressants

Domiciliary Hospitalization / Domiciliary Treatment

Sr. No.	Treatments
43	Multiple sclerosis / motorneuron disease
44	Status asthamaticus
45	Sequalea of meningitis
46	Osteoporosis
47	Muscular dystrophies
48	Sleep apnea syndrome(not related to obesity)
49	Any organ related (chronic) condition
50	Sickle cell disease
51	Systemic lupus erythematous (SLE)
52	Any connective tissue disorder
53	Varicose veins
54	Thrombo embolism venous thrombosis/venous thrombo embolism (VTE)]
55	Growth disorders
56	Graves' disease
57	Chronic Pulmonary Disease
58	Chronic Bronchitis
59	Physiotherapy and swine flu shall be considered for reimbursement under domiciliary treatment.

Annexure 2

From
Sri / Smt _____
_____
_____

To
The Manager / Sr Manager
HRM Section
Circle Office, _____

Sub: Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary treatment coverage as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name of the Employee / Spouse of the ex employee:

Name of the deceased retired employee:

Staff No:

Residential Address: _____
_____

1. I have read and fully understood the contents of HO Circular 552/2016 dated 14.10.2016 issued by Canara Bank conveying the renewal premium rates and domiciliary cover option by paying additional premium.

2. I am consenting to continue the said IBA Group Medical Insurance Policy, with Domiciliary Treatment coverage as per the Bipartite settlement / Joint Note, subject to payment of agreed Insurance Premium.

3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.

4. I authorize Canara Bank to debit the annual premium amount (presently Rs 20,010/- in case of Officer or Rs 14,950/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]

Annexure 3

From
Sri / Smt _____
_____
_____

To
The Manager / Sr Manager
HRM Section
Circle Office, _____

Sub: Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name of the Employee / Spouse of the ex employee:

Name of the deceased retired employee:

Staff No:

Residential Address: _____
_____

1. I have read and fully understood the contents of HO Circular 552/2016 dated 14.10.2016 issued by Canara Bank conveying the renewal premium rates and domiciliary cover option by paying additional premium.

2. I am consenting to continue the said IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage as per the Bipartite settlement / Joint Note, subject to payment of agreed Insurance Premium.

3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.

4. I authorize Canara Bank to debit the annual premium amount (presently Rs 16,025/- in case of Officer or Rs 12,020/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]

Annexure 4

Sub : Letter from the ex employee / spouses of the deceased ex employees for discontinuation from IBA Group Medical insurance policy

Name of the Employee / Spouse of the ex employee:

Name of the deceased retired employee:

Staff No:

Residential Address: _____

_____

Sub: Willingness/consent/Authorization letter to opt out of from the IBA Group Medical Insurance Scheme to Retirees:

1. I have read and fully understood the contents of HO Circular 552/2016 dated 14.10.2016 issued by Canara Bank.
2. I on my own volition has decided to discontinue / not to renew the IBA Group Medical Insurance Policy.
3. I understand that once if I opt out of the IBA Group Medical Insurance Policy, I will not be entitled to rejoin the policy in future.

Date:

[Signature]

Annexure 5

Name of the Spouse:

Name of the deceased retired employee & Staff no :

(Applicable only to spouses of Employee / retiree expired after 01.11.2015)

Residential Address: _____

_____

Sub: Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary treatment coverage as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name of the spouse :	
Name & Staff No. deceased employee/ retiree:	
Date of Birth of the Deceased Employee :	
Designation at the time of Retirement/death :	
Date of Retirement /death :	
Branch/office last worked :	
Circle office :	
Mode of Exit :	
Family Pension paying Account No :	
Operative Canara Bank SB Account in case on Non-Pensioners :	
Branch Name : DP Code : IFSC No. :	
PAN NO of spouse :	
Contact Telephone No. : Mobile No :	
Contact Email ID of spouse or relative :	

1. I have read and fully understood the contents of HO Circular HO Circular 552/2016 dated 14.10.2016 issued by Canara Bank.

2. Last year my spouse Sri / Smt _____( ), had opted for IBA Group Medical Group Insurance Policy & he/she has expired on _____ .

3. I am willing to continue the said Medical Insurance Policy, with Domiciliary Treatment coverage as per the Bipartite settlement / Joint Note, subject to payment of agreed Insurance Premium.

4. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.

5. I authorize Canara Bank to debit the annual premium amount (presently Rs 20,010/- in case of Officer or Rs 14,950/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my Pension SB account no / Operative Canara bank SB account no to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]

Annexure 6

Name of the Spouse:

Name of the deceased retired employee & Staff No:

(Applicable only to spouses of Employee / retiree expired after 01.11.2015)

Residential Address: _____

_____

Sub: Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name of the spouse :	
Name & Staff No. deceased employee/ retiree:	
Date of Birth of the Deceased Employee :	
Designation at the time of Retirement/death :	
Date of Retirement /death :	
Branch/office last worked :	
Circle office :	
Mode of Exit :	
Family Pension paying Account No :	
Operative Canara Bank SB Account in case on Non-Pensioners :	
Branch Name : DP Code : IFSC No. :	
PAN NO of spouse :	
Contact Telephone No. : Mobile No :	
Contact Email ID of spouse or relative :	

1. I have read and fully understood the contents of HO Circular 552/2016 dated 14.10.2016 issued by Canara Bank.
2. Last year my spouse Sri / Smt _____( ), had opted for IBA Group Medical Group Insurance Policy & he/she has expired on _____ .

3. I am willing to continue the said Medical Insurance Policy, without Domiciliary Treatment coverage as per the Bipartite settlement / Joint Note, subject to payment of agreed Insurance Premium.

4. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.

5. I authorize Canara Bank to debit the annual premium amount (presently Rs 16,025/- in case of Officer or Rs 12,020/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my Pension SB account no / Operative Canara bank SB account no to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]