ANNEXURE - II

Name of the Spouse:

Name of the deceased retired employee:

Staff No:

Residential Address:

Sub: Willingness/consent/Authorization letter to join in the Medical Insurance Scheme as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name of the spouse :	
Name & Staff No. deceased employee/ retiree:	
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 :	

I have gone through and understood the terms of Medical Scheme by way of insurance cover as mentioned under provisions of the 10th Bipartite Settlement / Joint Note dated 25.05.2015. I have also read and fully understood the contents of HO Circular ……./2015 dated ……..2015 issued by Canara Bank.

I am willing to join said Medical Insurance Scheme as per the Bipartite Settlement/ Joint Note dated 25th May, 2015 which is extended to the existing retirees subject to payment of agreed Insurance Premium by me.

The detail information of myself is under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

Sl. No	Full Name of Spouse .	Date of Birth (DD/M/YYYY)	Gender	Relationship	Photograph
					Spouse

I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme. My full particulars are as under:-

I authorize Canara Bank to debit the annual premium amount (Presently Rs.7494/- in case of officer or Rs.5621/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my Family Pension SB a/c No. /Operative Canara Bank SB Account No [as I am a non Family Pensioner] ……. 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.

I also fully understand that Bank is only facilitating the payment by obtaining this mandate, and it will be my responsibility to ensure that annual premium is paid.

Date:

[Signature]