ANNEXURE - II

Name :

Staff No:

Residential Address:

Sub: Willingness/Consent/Authorization letter to join in the Medical Insurance Scheme without Domiciliary Treatment coverage as per Bipartite Settlement/ Joint Note dated 25th May,2015.

Name & Staff No :	
Date of Birth :	
Designation at the time of Retirement :	
Date of Retirement :	
Branch/office last worked :	
Circle office :	
Mode of Exit :	
Pension paying Account No :	
Operative Canara Bank SB Account in case of Non-Pensioners :	
Branch Name : DP Code : IFSC No. :	
PAN No. :	
Contact Telephone No. : Mobile No :	
Contact Email ID of self or 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 443/2015 dated 07.09.2015 and subsequent Circulars issued in the matter including HO Circular 448/2019 dated 30.08.2019 issued by Canara Bank.

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

I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme. The detailed information of myself and spouse are as under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

Sl. No	Full Name of Self & Staff No / Name of Dependent Spouse.	Date of Birth (DD/MM/YYYY)	Gender	Relationship	Photograph
	Self				Self
	Spouse				Spouse

1. I authorize Canara Bank to debit the pro rata premium amount for one month (October 2019), (Rs.2445/- in case of officer or Rs.1834/- in case of workmen) from my Pension SB a/c No. /Operative Canara Bank SB Account No [as I am a non Pensioner] ……. to pay the premium now 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.

2. I fully understand that by paying the above amount I will only be covered for October 2019 and for further renewal of the policy for 2019-20 I have to pay premium as stipulated by the Insurance Company.

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]