



# सरदार स्वर्ण सिंह राष्ट्रीय जैव ऊर्जा संस्थान

(नवीन और नवीकरणीय ऊर्जा मंत्रालय, भारत सरकार का एक स्वायत्त संस्थान)  
12 कि.मी. स्टोन, जालंधर-कपूरथला रोड, वडाला कलां, कपूरथला (पंजाब) 144603  
फोन: 01822-507406, ईमेल: [sss.nibe@nibe.res.in](mailto:sss.nibe@nibe.res.in), वेबसाइट: <https://nibe.res.in>

## Sardar Swaran Singh National Institute of Bio-Energy

(An Autonomous Institute of Ministry of New and Renewable Energy, Government of India)  
12 K.M. Stone, Jalandhar-Kapurthala Road, Wadala Kalan, Kapurthala (Punjab) 144603  
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### PART-I

#### REIMBURSEMENT / ADVANCE FOR MEDICAL INSURANCE PREMIUM

#### 1. Personal Details:

Name of Employee	
Designation	
Department	
Date of Joining	
Pay Level & Basic Pay (01.07.20.....)	Rs.
IPD Claim Limit (40% of the basic pay)	Rs.

#### 2. Details of Policy Members (Employee+Dependents as per Service Book):

S. No	Name of Policy Members	Date of Birth & Age	Relation	Sum Assured	Insurance Premium (Rs)
1.					
2.					
3.					
4.					
5.					
6.					
TOTAL					

#### 3. Policy Type (✓ one):

- (i) Fresh (ii) Renewal  
(iii) Port (Previous Insurance Provider Name: \_\_\_\_\_)

#### 4. Mode of Payment for Insurance Premium (✓ one):

##### (i) Request for Reimbursement to the Employee:

- Insurance Company Name: \_\_\_\_\_
- Policy No. & Date: \_\_\_\_\_
- Policy Period: From \_\_\_\_\_ To \_\_\_\_\_
- Claimed Amount: Rs. \_\_\_\_\_
- Mode of Payment, Transaction ID & Date: \_\_\_\_\_
- Insurance Premium Payment Receipt Details: \_\_\_\_\_

**(ii) Request for Direct Payment to the Insurance Company** *(to be settled within 15 days):*

- Insurance Company Name: \_\_\_\_\_
- Amount to be paid: Rs. \_\_\_\_\_
- Quotation/Proforma Invoice/Supporting Document: \_\_\_\_\_
- **Bank Details of Insurance Company:**
  - Account Holder Name: \_\_\_\_\_
  - Bank Name: \_\_\_\_\_
  - Account No.: \_\_\_\_\_
  - IFSC Code: \_\_\_\_\_
  - Amounts: \_\_\_\_\_ (in word) \_\_\_\_\_

**(iii) Request for Advance Payment to the Employee** *(to be settled within 15 days):*

- Amount Requested Rs. \_\_\_\_\_
- Estimated Premium Expense Details: \_\_\_\_\_

**Declaration:** I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person(s) for whom medical expenses were incurred is wholly dependent on me.

**Documents enclosed** *(Self attested):*

- a)
- b)
- c)
- d)

Employee's Signature: .....

Employee's Name: .....

Contact No: .....

Email ID: .....

Date: .....

**(For Official Use)**

Passed Rs. ....(in word).....

(Signature)



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### PART-II

#### SETTLEMENT OF ADVANCE - MEDICAL INSURANCE PREMIUM

##### 1. Personal Details:

Name of Employee	
Designation	
Department	
Date of Joining	
Pay Level & Basic Pay (01.07.20.....)	Rs.
IPD Claim Limit (40% of the basic pay)	Rs.

##### 2. Details of Policy Members (*Employee + Dependents as per Service Book*):

S. No	Name of Policy Members	Date of Birth & Age	Relation	Sum Assured	Insurance Premium (Rs.)
1.					
2.					
3.					
4.					
5.					
6.					
TOTAL					

##### 3. Policy Type (✓ one):

(i) Fresh

(ii) Renewal

(iii) Port (*Previous Insurance Provider Name:* \_\_\_\_\_)

##### 4. Details of Payment Received:

###### (i) Direct Payment to the Insurance Company:

- Amount Paid: Rs. \_\_\_\_\_
- Date of Payment: \_\_\_\_\_

###### (ii) Advance Payment to the Employee:

- Amount Received: Rs. \_\_\_\_\_
- Date of Advance Received: \_\_\_\_\_

**5. Insurance Health Policy Details:**

- Insurance Company Name: \_\_\_\_\_
- Policy No. & Date : \_\_\_\_\_
- Policy Period: *From* \_\_\_\_\_ *To* \_\_\_\_\_
- Actual Premium Paid: Rs. \_\_\_\_\_
- Mode of Payment, Transaction ID & Date: \_\_\_\_\_
- Refund of Balance/ Excess amount (if any): \_\_\_\_\_

**Declaration:** I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person(s) for whom medical expenses were incurred is wholly dependent on me.

**Documents enclosed (*Self attested*):**

- a) Copy of Insurance Health Policy
- b) Payment Receipt
- c) .....
- d) .....

Employee's Signature: .....  
Employee's Name: .....  
Contact No: .....  
Email ID: .....  
Date: .....

**(For Official Use)**

Passed Rs.....(in word).....

(Signature)