**Post-Retirement Medical Benefit Claim Form**

**Organization Name  
Department  
Form No.**

1. **Retiree Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name | Mr. Ahmed Khan | Employee ID / Pension No. | 45821 |
| Date of Birth | 12-Mar-1958 | Date of Retirement | 31-Mar-2023 |
| Designation at Retirement | Senior Accounts Officer | Contact No. | +92 300 1234567 |
| Email Address | ahmed.khan @email.com | Residential Address | 24-A Sunset Boulevard, Lahore |

1. **Medical Treatment Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Treatment** | **Name of Hospital / Clinic** | **Nature of Illness / Treatment** | **Doctor’s Name** | **Total Bill (PKR)** |
| 05-Oct-2025 | Shifa Medical Center | Consultation & Blood Tests | Dr. Naila Tariq | 6,000 |
| 06-Oct-2025 | Shifa Medical Center | X-ray and ECG | Dr. Naila Tariq | 4,500 |
| 10-Oct-2025 | Shifa Medical Center | Medication | Dr. Naila Tariq | 3,200 |
| **Total Medical Expense (PKR)** | | | | → **13,700** |

1. **Claim Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| Total Medical Expenses | 13,700 | Eligible Reimbursement (%) | 80% |
| **Claim Amount Payable** | **10,960** |  |  |

1. **Bank / Payment Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Bank Name | Habib Bank Limited | Branch | Lahore Main |
| Account Title | Ahmed Khan | Account Number | 1234-567890 |
| IBAN | PK12HABB0000001234567890 | | |

**E. Required Attachments (Checklist)**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Original medical bills and receipts | ☐ Doctor’s prescription(s) | ☐ Discharge summary (if hospitalized) | ☐ Copies of diagnostic reports |
| ☐ Copy of pensioner’s ID / CNIC |  |  |  |

**F. Declaration by Retiree**

I hereby declare that the above information is true and the expenses claimed were actually incurred by me for my medical treatment. I have not claimed these expenses from any other source.

**Signature of Retiree:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**G. Office Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Verified By** | **Designation** | **Signature** | **Date** |
| HR Officer |  |  |  |
| Accounts Officer |  |  |  |
| Department Head Approval |  |  |  |

**Remarks:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Approved Reimbursement Amount:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_