



**No: A.60011/30/2017/HRPC/Pt.I/188**

**Date: 13<sup>th</sup> August, 2021**

The Regional Executive Director  
Airports Authority of India  
Northern/Western/Eastern/Southern/North-East Region  
Delhi/Mumbai/Kolkata/Chennai/Guwahati

The Executive Director,  
Airports Authority of India  
RCDU/FIU, New Delhi

The Airport Director  
Airports Authority of India  
Kolkata/Chennai Airport

The Director,  
Indian Aviation Academy,  
New Delhi

The Principal,  
Civil Aviation Training College (CATC),  
Bamrauli, Prayagraj

The General Manager,  
Airports Authority of India  
CRSD/E&M Workshop,  
New Delhi

## **Corporate HRM Circular No. 20 (a) / 2019**

### **Sub: Forms Regarding Revised AAI Medical Policy**

Further to CHRM Circular No. 20/2019 dated 08.04.2019, in order to remove any confusion, FORM-B has been modified and now it is only an Option Form for Superannuated / Separated employees and a separate form has been added as Life Certificate for Superannuated / Separated employees.

2. Accordingly, all the Medical Forms i.e. FORM-A to FORM-H are enclosed for uniform applicability across all offices of AAI as follows:

- FORM A: Option Form for Reimbursement of Medical Claim for Serving Employees. To be submitted through Employee Self Service (ESS) Portal.
- FORM B: Option Form for Reimbursement of Medical Claim for Superannuated/ Separated Employees (as per AAI Retired Medical Scheme)
- FORM C: Quarterly Medical Reimbursement Form for Serving Employees, who have opted Scheme-B, on self-certification basis. To be submitted through Employee Self Service (ESS) Portal.
- FORM D: Quarterly Medical Reimbursement Form for Superannuated/ Separated Employees (as per AAI Retired Medical Scheme), who have opted Scheme-B, on self-certification basis.
- FORM E: Medical Reimbursement Form for OPD Expenses (Those who have opted Scheme-A) and Chronic Disease (Those who have opted Scheme-A or Scheme-B) for Serving and Superannuated/Separated Employees.

*R. Prasad*

- FORM F: Medical Reimbursement Form for Serving and Superannuated/Separated Employees (as per AAI Retired Medical Scheme) who have opted for either Scheme-A or Scheme-B in respect to Dental and Physiotherapy Charges.
  - FORM G: Life Certificate for Superannuated/Separated Employees (as per AAI Retired Medical Scheme)
  - FORM H: Medical Reimbursement Form in respect of Laboratory Tests for Serving and Superannuated/Separated Employees (as per AAI Retired Medical Scheme) who have opted for either Scheme-A or Scheme-B.
3. Further it is intimated that Form-A, Form-B and Form-G are to be submitted in HR Department and Form-C, Form-D, Form-E, Form-F and Form-H are to be submitted in Finance Department.
4. This issues with the approval of the competent authority.

*R. Prabhu*  
(R. Prabhu)

**Executive Director (HR)**

**Distribution: -**

- ❖ OSD to Chairman
- ❖ DGM (ES) to Member(HR)/ Member(Ops)/ Member(Plg)/ Member(ANS)/ Member (Fin)/ CVO
- ❖ All HoDs at CHQ / Operational Office / AAI Office Complex
- ❖ ED (HR-II) / All GM (HR) at CHQ
- ❖ GM (HR-SAP)- For configuration in SAP
- ❖ GM (IT) for uploading on AAI Website
- ❖ GS, AAEU/ GS, IAKU/ GS, AAIEG/ GS, ATCG(I)/ GS, IAAIOA/ GS, AAI SC/ST EWA/ GS, AAI SC/ST/OBC (NE) EWA
- ❖ Hindi version will follow



# Airports Authority of India

## Option Form for Reimbursement of Medical Claim for Serving Employees

1.	Name of Employee	
2.	Employee Number	
3.	Designation	
4.	Department/ Place of Posting	
5.	Medical Reimbursement Option for Financial Year (_____)	<input type="checkbox"/> Scheme A      OR <input type="checkbox"/> Scheme B (Tick One Option)

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

**Form- B**

**Airports Authority of India**  
**Option Form for Reimbursement of Medical Claim for**  
**Superannuated/Separated Employees**  
**(as per AAI Retired Medical Scheme)**

1.	Name of Ex-Employee			
2.	Ex-Employee Number			
3.	Designation at Superannuation/Separation			
4.	Department/ Place of Posting at Superannuation/Separation			
5.	Present Residential Address			
6.	Date of Superannuation /Separation (Retirement/Death etc.)			
7.	Phone Number			
8.	Email Address			
9.	PAN Number			
10	Medical Reimbursement Option for Financial Year (_____)	<input type="checkbox"/> Scheme A      OR <input type="checkbox"/> Scheme B (Tick One Option)		
11.	Dependent List			
S.No	Name of Dependent	Relationship	Date of Birth	Whether PWD (yes/no)

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

Name: \_\_\_\_\_

**Note:** In case of death of an employee the form shall be signed by his/her spouse/admissible dependent.



Form- C

# Airports Authority of India

## Quarterly Medical Reimbursement Form for Serving Employees on Self Certification (Those who have opted Scheme –B)

1.	Name of Employee						
2.	Employee Number						
3.	Designation						
4.	Period of Medical Claim (to be submitted at the end of each quarter)						
Qtr	Day	Month	Year		Day	Month	Year
Qtr 1	1 <sup>st</sup>	April		To	30 <sup>th</sup>	June	
Qtr 2	1 <sup>st</sup>	July		To	30 <sup>th</sup>	September	
Qtr 3	1 <sup>st</sup>	October		To	31 <sup>st</sup>	December	
Qtr 4	1 <sup>st</sup>	January		To	31 <sup>st</sup>	March	

This is certified that I had spent Rs. \_\_\_\_\_  
(Rupees \_\_\_\_\_) towards OPD  
treatment for myself and admissible dependents (if any) during the period mentioned  
above and the same has not be claimed from any other source.

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_



Form- D

## Airports Authority of India

### Quarterly Medical Reimbursement Form for Superannuated/Separated Employees (as per AAI Retired Medical Scheme) on Self Certification (Those who have opted Scheme –B)

1.	Name of Ex-Employee						
2.	Ex-Employee Number						
3.	Designation at Superannuation/Separation (Retirement/Death etc.)						
4.	Date of Superannuation/ Separation (Retirement/Death etc.)						
5.	Period of Medical Claim (to be submitted at the end of each quarter)						
QTR	Day	Month	Year		Day	Month	Year
Qtr 1	1 <sup>st</sup>	April		To	30 <sup>th</sup>	June	
Qtr 2	1 <sup>st</sup>	July		To	30 <sup>th</sup>	September	
Qtr 3	1 <sup>st</sup>	October		To	31 <sup>st</sup>	December	
Qtr 4	1 <sup>st</sup>	January		To	31 <sup>st</sup>	March	

This is certified that I had spent Rs \_\_\_\_\_ (Rupees \_\_\_\_\_) towards OPD treatment for myself and admissible dependents (if any) during the period mentioned above and the same has not be claimed from any other source.

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

Name: \_\_\_\_\_

**Note:** In case of death of an employee the form shall be signed by his/her spouse /admissible dependent.



Form- E

## Airports Authority of India

### **Medical Reimbursement Form for OPD Expenses (Those who have opted Scheme –A) and Chronic Disease (Those who have opted Scheme-A or Scheme-B) for Serving Employees and Superannuated/Separated Employees**

1.	Name of Employee	
2.	Employee Number	
3.	Whether Serving or Superannuated/Separated (tick one option)	<input type="checkbox"/> Serving Employee OR <input type="checkbox"/> Superannuated/Separated Employee
4.	Residential address of Employee	
5.	Select the Relevant Option	<input type="radio"/> Reimbursement of OPD Expenses under Scheme A <input type="radio"/> Reimbursement of Chronic Disease under Scheme A <input type="radio"/> Reimbursement of Chronic Disease under Scheme B
6.	Name & Age of the patient	
7.	Relationship with employee	
8.	Name & Address of the Doctor	
9.	Period of Treatment	
10.	Details of Expenditure	
	Consultation Fee	
	Cost of Medicine	
	Other Charges (Pathological /Radiological test etc.)	
	Total Amount	

**Certificate:**

1. The particulars given above are true to the best of my knowledge and belief.
2. The patient for whom medical reimbursement is submitted has not been claimed from any other sources.
3. The patient for whom medical reimbursement is submitted is wholly dependent on me

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

Name: \_\_\_\_\_

**Note:**

1. Original bills/invoice need to be enclosed.
2. In case of death of an employee the form shall be signed by his/her spouse/admissible dependent.
3. Separate form shall be submitted for each treatment.



Form- F

## Airports Authority of India

### Medical Reimbursement Form in respect of Dental/Physiotherapy Charges for Serving Employees and Superannuated/Separated Employees (as per AAI Retired Medical Scheme)

(Those who have opted either Scheme –A or Scheme-B)

1.	Name of Employee	
2.	Employee Number	
3.	Whether Serving or Superannuated/Separated (tick one option)	<input type="checkbox"/> Serving Employee OR <input type="checkbox"/> Superannuated/Separated Employee
4.	Residential address of Employee	
5.	Name & Age of the patient	
6.	Relationship with employee	
7.	Name & Address of the Doctor	
8.	Period of treatment	
9.	Details of treatment	
10.	Details of Expenditure towards Dental/Physiotherapy	
	Consultation Fee	
	Cost of Medicine/ Treatment	
	Total Amount	

**Certificate:**

1. The particulars given above are true to the best of my knowledge and belief.
2. The patient for whom medical reimbursement is submitted has not been claimed from any other sources.
3. That the patient for whom medical reimbursement is submitted is wholly dependent on me.

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

Name: \_\_\_\_\_

**Note:**

1. Original bills/invoice need to be enclosed.
2. In case of death of an employee the form shall be signed by his/her spouse/admissible dependent.
3. Separate form shall be submitted for each treatment.



Form- G

# Airports Authority of India

## LIFE CERTIFICATE

### For Superannuated/Separated Employees (as per AAI Retired Medical Scheme)

I, \_\_\_\_\_, ex-employee, spouse of ex-employee (Late) Sh./Smt. \_\_\_\_\_, certify that myself and my admissible dependents, as mentioned below, are enrolled under the AAI Medical Policy and are alive as on date:

1.	Name of Admissible Dependent:		Relation:	
2.	Name of Admissible Dependent:		Relation:	
3.	Name of Admissible Dependent:		Relation:	
4.	Name of Admissible Dependent:		Relation:	
5.	Name of Admissible Dependent:		Relation:	

Signature of the AAI Retired Official/  
\*Spouse/\*Admissible Dependent

Place: \_\_\_\_\_  
Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Ex-Employee No: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

*\*In case of death of an AAI employee, the form shall be signed by his/her spouse/Admissible dependent.*

I, \_\_\_\_\_ hereby certify that Sh./Smt. \_\_\_\_\_ is alive as on date. I am fully satisfied about his/her identity.

Counter Signature of Authority (Stamped)

Place: \_\_\_\_\_  
Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Designation: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

*Note: The above mentioned form should be counter-signed by any of the below mentioned official*

1. Government Gazette Officer
2. Bank Branch Manager
3. Doctor in Government Hospital
4. Doctor in any of the Empaneled Hospital of AAI
5. Manager (E-3) and above level working officer of AAI who is not in blood relation of the retired official.



Form- H

## Airports Authority of India

### Medical Reimbursement Form in respect of Laboratory Tests for Serving Employees and Superannuated/Separated Employees (As per AAI Retired Medical Scheme) (Those who have opted either Scheme-A or Scheme-B)

1.	Name of Employee	
2.	Employee Number	
3.	Whether Serving or Superannuated/Separated (tick one option)	<input type="checkbox"/> <input type="checkbox"/> Serving Employee OR Superannuated/Separated Employee
4.	Residential address of Employee	
5.	Name & Age of the patient	
6.	Relationship with employee	
7.	Name & Address of the Doctor	
8.	Period of Treatment	
9.	Select the Type of Test	<ul style="list-style-type: none"><li>▪ MRI Scan</li><li>▪ CT Scan</li><li>▪ PET Scan</li><li>▪ Cancer or Tumor Marker Test</li><li>▪ Nuclear Medicine Imaging/ Test</li><li>▪ DEXA Scan</li><li>▪ Biopsy (including CT guided), if done as OPD procedure</li><li>▪ EEG (Electro-Encephalogram)</li><li>▪ ERCP</li></ul>
10.	Name of any other single test costing more than Rs. 3000/-	
11.	Details of Expenditure towards Laboratory Tests	
	Bill Details	
	Total Amount	

#### Certificate:

1. The particulars given above are true to the best of my knowledge and belief.
2. The patient for whom medical reimbursement is submitted has not been claimed from any other source
3. The patient for whom medical reimbursement is submitted is wholly dependent on me

Date: \_\_\_\_\_

(Signature)

Place: \_\_\_\_\_

Name: \_\_\_\_\_

#### **Note:**

1. Original bills/invoice need to be enclosed.
2. In case of death of an employee the form shall be signed by his/her spouse/admissible dependent.
3. Separate form shall be submitted for each treatment.