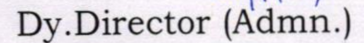
DELHI URBAN SHELTER IMPROVEMENT BOARD
GOVERNMENT OF N.C.T. OF DELHI
(ADMINISTRATION BRANCH)

D-802/Dy.Director (Admn.)/2017 Dated-25/9/2017

To introduce cashless medical facilities in DUSIB, it has been decided that medical identity card be issued to all the regular serving employees, Retired employees and the family pensioners. All the serving/retired/family pensions are requested to fill up the relevant portion of the attached Performa, adhering to the instructions given therein and submit the same to their concerned DDOs latest by 29.9.2017. The Performa can be obtained from the Administration Branch, Care Taking Branch, and Medical Cell or from the concerned DDOs. Copy of the Performa can also be downloaded from web-site

All DDOs are also requested to take necessary action for obtaining relevant performa from all the serving/retired/family pensioners whose files are under their custody within scheduled time.

Encl:-As above.



Dy.Director (Admn.)

Distribution:

1. Member (Admn.)/(Finance)/(Enggr.) for kind information.
2. Pr.Director (Admn.)
3. All S.Es (DUSIB)
4. All Deputy Directors for kind information.
5. All E.Es for compliance.
6. Dy.Director (System) with the request to upload the same to the DUSIB website.
7. Dy.Director (GA) with the request to display the circular at the conspicuous place at various locations of the Department and as per circular.
8. President (Pensioners Association) 145,Gagan Vihar, Delhi-92
9. Office Copy/Guard file.

INSTRUCTIONS

Please obtain the requisite form as classified below-

FORM-'A'----------------FOR SERVING EMPLOYEE

FORM-'B'----------------FOR PENSIONERS

FORM-'C'----------------FOR FAMILY PENSIONERS

1. Please read the instructions carefully before filling the form in ENGLISH in CAPITAL LETTERS and in BLUE/BLACK ball point pen only.
2. Please paste recent colour photograph of size 3.5 cm x 4.5 cm in white background of self and dependents showing frontal view of full face. Photographs should be clear with white background.
3. Please put your Signature of Thumb impression within the space provided on.
4. **Name** – Should be as per Service Record using maximum of 20 Characters including space.
5. **Father's/Husband's Name** – Should be as per Service Record using maximum of 20 Characters including space.
6. **Designation** – Your present designation in DUSIB.
7. **Date of Birth/Date of Retirement** – As per your service record.
8. **Date of issu8e of DUSIB Medical Identity Card and number** – Your existing DUSIB Medical Identity Card number and mention date of issue (If any)
9. **Pay in pay band**- Your present pay drawn at the time of filling up this form in the existing pay band. **Grade Pay** – Write your existing grade pay as per service record.
10. **Present place of posting** – Write name of place where you are presently posted.
11. **Residential Address** – Write your full residential address as given in your service record along with PIN Code.
12. **Telephone /Mobile** – Write your telephone/mobile number where you can be contacted in case of emergency.
13. **Are you on deputation/Name of parent Deptt.** – Write YES or NO. Give name of your parent Department from which you have come on deputation to DUSIB.
14. **Address of Controlling Office of parent Deptt.** – Write complete address of accounting authority of your organization from which you have come on deputation to DUSIB.
15. **Expiry date of Deputation** – Write the date when your Deputation to DUSIB would finish.

16. **Details of Medical Contribution (To be attested by DDO)** - Mention amount of deduction made from your salary under existing medical scheme duly attested by DDO.
17. **Whether spouse is working in Central Govt. /Private organization** - Write YES or NO.
18. **If yes, mention complete name and address of the Spouse office** - If YES, please write full name and address along with PIN Code of the office.
19. **Whether Medical facilities availing in that office** - Write YES or NO.
20. **Is he/she willing to avail medical facilities under DUSIB Medical Scheme** - Please give your willingness i.e. YES or NO.
21. **If yes, have you submitted the joint declaration form** - If you are willing to avail medical facilities under DUSIB Medical Scheme, then please fill the Joint Declaration form duly filled by office of the spouse to be submitted to Sr. AO Medical Cell, Vikas Kutir/Punerwas Bhawan.
22. **Are your children studying .... treated as dependents)** - Write YES or NO.
23. **14(i) Are your parents dependent on you** - Write YES or NO.
24. **Are they living with you and since when** - Write YES or NO. Write month and year since when your parents have been residing with you.
25. **Are they availing .... From any other source** - Write YES or NO.
26. **Are they pensioner** - Write YES or NO.

FORM – A

DELHI URBAN SHELTER IMPROVEMENT BOARD

Application Form for Medical Identity Card

Read the application form carefully. Fill the form in ENGLISH in CAPITAL LETTERS and in BLUE/BLACK ball point pen only

Aadhar No.: [__]-[__]-[__]-[__] [__]-[__]-[__]-[__] [__]-[__]-[__]-[__]

PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5

1. Name ______________________________

2. Father's/Husband's Name______________________________

3. Designation______________________________

4. Date of Birth (DD/MM/YYYY) __/__/__

   Date of Retirement (DD/MM/YYYY) __/__/__

5. Number of existing DUSIB Medical identity Card and date of issue______________

6. Pay in pay band ______________ Grade Pay __________Level___________

7. Present place of posting ______________________________

8. Residential Address (along with pin code) ______________________________

   ____

   ____

9. Telephone/Mobile ______________________________

10.(i) Are you on deputation? Name of parent Deptt. ______________________________

(ii) Address of Controlling Office of parent Deptt. ______________________________

(iii) Expiry date of Deputation ______________________________

11. Details of medical contribution
    (To be attested by DDO) ______________________________

    ____

12.(i) Whether spouse is working in Central Govt./State Statutory Autonomous Body/Public Sector Enterprise/local body/private organization?______________________________

(ii) If yes, mention complete name and address of the Spouse office ______________

____

(iii) Whether medical facilities availing in that office? ______________

(iv) Is he/she is willing to avail medical facilities under DUSIB Medical Scheme? ________

(v) If yes, have you submitted the joint declaration form? ______________

13. Are your children studying or employed? (Married, employed children & sons more than 25 years of age shall not be treated as dependents) (Son suffering from permanent disability irrespective of age limit are treated as dependents.)

____

14. (i) Are your parents dependent on you? ______________

(ii) Are they living with you and since when? ______________

(iii) Are they availing any medical facility as dependent from any other source? ________

(iv) Are they pensioner? ______________

(v) Details of their income from all sources______________

Declaration

I solemnly declare that I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Dependent______________

Name of Spouse ______________ Relation ______________

Date of Birth ______________ Date of Birth ______________

1 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm	2 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm

Name of Dependent______________ Name of Dependent______________

Relation ____________________	Relation ____________________
Date of Birth ____________________	Date of Birth ____________________
3 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm	4 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm
Name of Dependent ____________________	Name of Dependent____________________
Relation ____________________	Relation ____________________
Date of Birth ____________________	Date of Birth ____________________
5 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm	6 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm
Name of Dependent____________________	Name of Dependent____________________
Relation ____________________	Relation ____________________
Date of Birth ____________________	Date of Birth ____________________
7 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm	8 PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5 cm

2. That the total monthly income (from all sources including income from house/other immovable property/fixed deposit etc.) of my dependent father and/or dependent mother is less than Rs.9000/-

3. That my child/children is/are dependent on me and is/are NOT earning Rs.9000/- or more per month & that my daughter(s) is/are NOT married. That age of my son/sons is/are not more than 25 years.

4. That in case of any change in the status of my dependents (due to death, marriage, employment), I will inform Senior AO (Medical) at the earliest and will stop availing DUSIB Medical facilities. I will refund in full, the cost of any treatment that my dependent may have received after he/she became ineligible. I shall be liable for disciplinary action should I fail to do so.

5. That I am NOT a member of any other medical scheme funded by Central Govt. PSU or any other Pvt./Govt. organization.

6. That my spouse & dependent family member(s) is NOT a member of CGHS or any other Govt./Pvt. Medical Scheme.

7. I understand that in case I have submitted any incorrect information, or if my DUSIB Medical Identity Card is misused or used by any unauthorized person, my membership will be cancelled without any notice or further hearing. In addition, I will pay the entire cost of expenditure incurred on such unauthorized person(s). I will also be liable for legal action by the DUSIB. I will also immediately report the loss of my DUSIB Medical Identity Card to the Medical Cell, DUSIB.

8. I shall return my Medical Identity Card issued to me to Medicard Section on retirement/cessation of Service/Deputation/Reversion to my parent department.

Place.....................

Date...........................

Signature ....

Name ....

Designation...............................

For Office Use only

Certified that information furnished by the applicant has been verified.

Further the entitlement of the member included in this card has been checked strictly as per DUSIB Medical Scheme / CS (MA) Rules.

Signature ____________________________________

Name ____

Designation __________________________________

Branch Officer/Head of Office ___________________

Date: ________________________

Verified the information furnished by the official entitled to category:-

PRIVATE / **SEMI PRIVATE** / **GENERAL WARD**

Signature ______________________________
(D.D.O.)

Name _________________________________

Date: _______________ Designation ____________________________

Sh./Smt. ________________________________ Enrolled in DUSIB on dated _______________ issued Medical Identity Card No. ______________________________

Date: ____________ Signature (D.D.O.) _______________

Name __________________ Designation ________

FORM – B

DELHI URBAN SHELTER IMPROVEMENT BOARD

Application Form for Medical Identity Card for DUSIB Pensioners

Note: Read the application form carefully before filling the form in ENGLISH in CAPITAL LETTERS and in BLUE/BLACK ball point pen only

Aadhar No.: [__]-[__]-[__]-[__] [__]-[__]-[__]-[__] [__]-[__]-[__]-[__]

PASTE PASSPORT SIZE COLOURED PHOTO OF 3.5 X 4.5 CM WITH WHITE BACK GROUND

1. Name ____________________

2. Father's/Husband's Name____________________

3. Designation at the time of retirement____________________

4. Date of Birth (DD/MM/YYYY) __/__/__ Date of Retirement (DD/MM/YYYY) __/__/__

5. Last Basic Pay Drawn ____________ PPO No. ____________________
(Excluding Grade Pay)

6. Residential Address (along with pin code) ____________________

____

____

7. Telephone/Mobile ____________________

8. Number of existing DUSIB Medical Identity Card and date of issue ____________

9. Number of existing Biometric Medical Card collected while in service and date of surrender ____________________

Following contributions has/have been paid by me. Copies of receipt are attached.

Sl. No.	Receipt No.	Date	Amount	Remarks (Receipt attached/ not attached)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Declaration

I solemnly declare that I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Spouse ____________________

Date of Birth ____________________

Name of Dependent____________________

Relation ____________________

Date of Birth ____________________

1
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

2
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent____________________

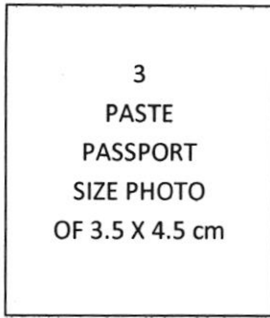
Relation ____________________

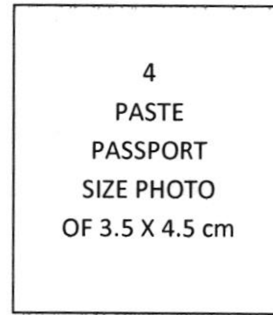
Date of Birth ____________________

Name of Dependent____________________

Relation ____________________

Date of Birth ____________________





Name of Dependent ____________________ Name of Dependent____________________

Relation ____________________ Relation ____________________

Date of Birth ____________________ Date of Birth ____________________

2. That the total monthly income (from all sources including income from house/other immovable property/fixed deposit etc.) of my dependent father and/or dependent mother is less than Rs.9000/-

3. That my child/children is/are dependent on me and is/are NOT earning Rs.9000/- or more per month & that my daughter(s) is/are NOT married. That age of my son/sons is/are not more than 25 years.

4. That in case of any change in the status of my dependents (due to death, marriage, employment), I will inform Senior AO (Medical) at the earliest and will stop availing DUSIB Medical facilities. I will refund in full, the cost of any treatment that my dependent may have received after he/she became ineligible. I shall be liable for disciplinary action should I fail to do so.

5. That I am NOT a member of any other medical scheme funded by Central Govt. PSU or any other Pvt./Govt. organization.

6. That my spouse & dependent family member(s) is NOT a member of CGHS or any other Govt./Pvt. Medical Scheme.

7. I understand that in case I have submitted any incorrect information, or if my DUSIB Medical Identity Card is misused or used by any unauthorized person, my membership will be cancelled without any notice or further hearing. In addition, I will pay the entire cost of expenditure incurred on such unauthorized person(s). I will also be liable for legal action by the DUSIB. I will also immediately report the loss of my DUSIB Medical Identity Card to the Medical Cell, DUSIB.

8. I shall return my Medical Identity Card issued to me to Medicard Section on retirement/cessation of Service/Deputation/Reversion to my parent department.

Place.....................

Date............................

Signature ....

Name ....

Designation..............................

VERIFICATION

(a) Medical contribution of Rs. ..../- has been paid by above named pensioner vide cash receipt has been verified from the records/receipts.

(b) Further the entitlement of the member included in this card has been checked strictly as per DUSIB Medical Scheme/CS (MA) Rules.

Entitled to Category:- **Private / Semi-Private / General Ward**

AD Medical/Sr. AO (Medical)

For Office Use Only

Card No. ______________________________ Issued on ______________

FORM – C

DELHI URBAN SHELTER IMPROVEMENT BOARD

Application Form for Medical Identity Card for DUSIB Family Pensioners

Note: Read the application form carefully before filling the form in ENGLISH in CAPITAL LETTERS and in BLUE/BLACK ball point pen only

Aadhar No.: [__]-[__]-[__]-[__] [__]-[__]-[__]-[__] [__]-[__]-[__]-[__]

PASTE PASSPORT SIZE COLOURED PHOTO OF 3.5 X 4.5 CM WITH WHITE BACKGROUND

1. Name of Family Pensioner____________________

2.(i) Name of DUSIB Employee ____________________

(ii) Father's /Husband's Name of DUSIB Employee ____________

(iii) Relationship of Family Pensioner with Employee ____________

(iv) Date of retirement/Death of DUSIB Employee ____________________

(v) Designation at the time of Retirement/Death of DUSIB Employee/Pensioner ________

____

(vi) Basic Pay at the time of Retirement/Death of DUSIB Employee/Pensioner ________

(vii) PPO No. ______________________________

3. Date of Birth (DD/MM/YYYY) of Family Pensioner ____________________

4. Number of existing DUSIB Medical identity Card and date of issue____________

5. Number of existing Biometric Medical Card collected while in service and date of surrender ______________________________

6. Residential Address (along with pin code) ____________________

____

____

7. Telephone/Mobile ______________________________

Declaration:-

I solemnly declare that I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Spouse ______________________

Date of Birth ______________________

Name of Dependent ______________________

Relation ______________________

Date of Birth ______________________

1
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

2
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent ______________________

Relation ______________________

Date of Birth ______________________

Name of Dependent ______________________

Relation ______________________

Date of Birth ______________________

2. That the total monthly income (from all sources including income from house/other immovable property/fixed deposit etc.) of my dependent father and/or dependent mother is less than Rs.9000/-

3. That my child/children is/are dependent on me and is/are NOT earning Rs.9000/- or more per month & that my daughter(s) is/are NOT married. That age of my son/sons is/are not more than 25 years.

4. That in case of any change in the status of my dependents (due to death, marriage, employment), I will inform Senior AO (Medical) at the earliest and will stop availing DUSIB Medical facilities. I will refund in full, the cost of any treatment that my dependent may have received after he/she became ineligible. I shall be liable for disciplinary action should I fail to do so.

5. That I am NOT a member of any other medical scheme funded by Central Govt. PSU or any other Pvt./Govt. organization.

6. That my spouse & dependent family member(s) is NOT a member of CGHS or any other Govt./Pvt. Medical Scheme.

7. I understand that in case I have submitted any incorrect information, or if my DUSIB Medical Identity Card is misused or used by any unauthorized person, my membership will be cancelled without any notice or further hearing. In addition, I will

pay the entire cost of expenditure incurred on such unauthorized person(s). I will also be liable for legal action by the DUSIB. I will also immediately report the loss of my DUSIB Medical Identity Card to the Medical Cell, DUSIB.

8. I shall return my Medical Identity Card issued to me to Medicard Section on retirement/cessation of Service/Deputation/Reversion to my parent department.

Place.....................

Date............................

Signature ....

Name ....

Designation...............................

For Office Use only

Certified that information furnished by the applicant has been verified.

Further the entitlement of the member included in this card has been checked strictly as per DUSIB Medical Scheme / CS (MA) Rules.

Entitled to Category:- **PRIVATE / SEMI PRIVATE / GENERAL WARD**

Sr. AO(Medical)/(Pension)

Signature (DDO)

Name ____________ Designation ____________ Name __________ Designation ____________

Date: __________________ Date ____________________

Sh./Smt. ____________________________________ Enrolled in DUSIB on dated ________________ issued Medical Identity Card No. _________________________________

Date: ____________

D.D.O./AO (Medical)