

DELHI URBAN SHELTER IMPROVEMENT BOARD
GOVT. OF N.C.T. OF DELHI
(ADMINISTRATION BRANCH)
F-04, Vikas Kuteer, I.T.O, I.P. Estate, Delhi-110002.

No: D-584/Dy.Dir(Admn)/2020


Date: 16/9/2020

Kindly find enclosed a copy of circular D-802/Dy. Director (Admn.)/2017 dated 25.09.2017 alongwith subsequent corrigendum with partial modification in letter no. D-802/Dy. Director (Admn.) dated 25.09.2017 in respect of medical facilities in DUSIB.

Dy. Director (IT) with a request that enclosed copy may be uploaded on the website in place of previous circular dated 25.09.2017 which is available on the site of the department in Administration Circulars & Orders section and previous circular dated 25.09.2017 may be removed from the website of DUSIB.

Encl: As above.

Dy. Dir (IT)


Dy. Director (Admn.)

Diary No. 998
Date: 17/9/20
Computer Division (DUSIB)
Govt. of NCT of Delhi

DELHI URBAN SHELTER IMPROVEMENT BOARD
GOVT. OF N.C.T. OF DELHI
ADMINISTRATION BRANCH
A-Block, Second Floor, Vikas Bhawan-II, Civil Lines, Delhi-110054

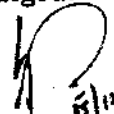
No. GA/1092/10/2017/D-944

Date: 15/12/17

CORRIGENDUM

In partial modification of letter No. D-802/Dy. Director (Admn)/2017 dated 25.09.2017, the word "**Cashless Medical Facilities**" may be read as "**Medical Facilities**".

The rest of the contents of the circular will remain unchanged.


Dy. Director (Admn.)

Distribution:

1. Member (Admn.)/Finance/Engineer.
2. Pr. Director (Admn.)
3. All S.Es
4. F.A/All Directors/B&FO/Architect
5. All Deputy Directors for kind information.
6. All E.Es
7. Dy. Dir (System) with the request to upload the same to the DUSIB website.
8. President(Pensioners Association) 145, Gagan Vihar , Delhi-92
9. Office Copy/Guard File.

**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.


25/9/17
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 location, 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 issue 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.

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

1. Name _____
 2. Father's/Husband's Name _____
 3. Designation _____
- PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5
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 _____

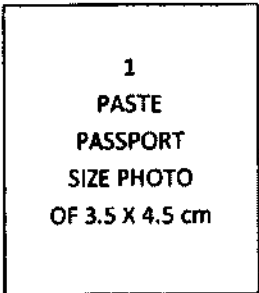
Declaration

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 _____



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.....

Signature

Date.....

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 _____

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

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 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 _____

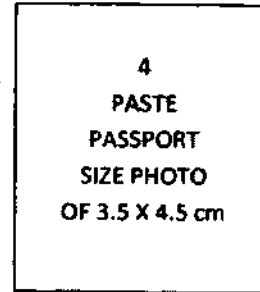
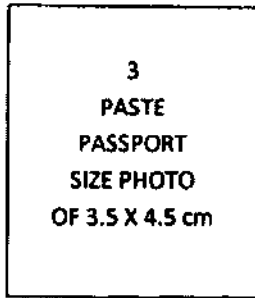
Name of Dependent _____

Relation _____

Relation _____

Date of Birth _____

Date of Birth _____



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.....

Signature

Date.....

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 _____

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

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) _____

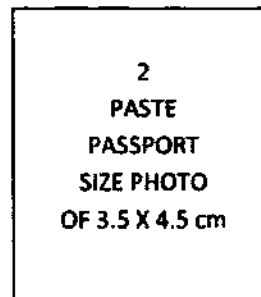
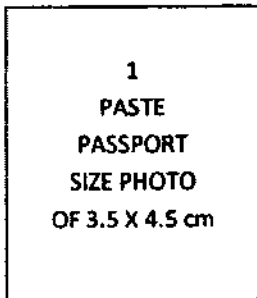
7. Telephone/Mobile _____

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

Declaration:-

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

Name of Spouse _____ Name of Dependent _____
Relation _____
Date of Birth _____ 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.....

Signature

Date.....

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)