DELHI URBAN SHELTER IMPROVEMENT BOARD

APPLICATION FORM FOR MEDICAL IDENTITY CARD FOR SERVING EMPLOYEES/PENSIONER /FAMILY PENSIONERS

ALL REGULAR SERVING EMPLOYEES/RETIRED EMPLOYEES/FAMILY PENSIONERS ARE REQUESTED TO FILL UP THE RELEVANT PORTION OF THE ATTACHED PERFORMA, ADHERING TO THE INSTRUCTIONS GIVEN THEREIN AND SUBMIT TO THEIR CONCERNED DDOS.

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, and then please fill the Joint Declaration form duly filled by office of the spouse to be submitted to Sr. AO Medical Cell/ Admn. Branch 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 for Serving Employees

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

PASTE PASSPORT SIZE PHOTO OF 3.5 X 4.5

1. Name of the employee (in capitals)

_____

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 (If any issued)

_____

6. Pay Band ---------- Present Pay with Pay Matrix Level _____

   Grade Pay---------

   (Encl: -Last Pay certificate / Slip)

7. Present place of posting: _____

8. Residential Address (along with pin code): _____

   _____

   _____

9. Telephone/Mobile with E-mail ID

_____

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 (per month) (To be attested/verified by DDOs):

_____

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, you have to submit the joint declaration form / undertaking and a certificate from spouse's working department: _____

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 and undertake that: 1. I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Spouse _____

Relation _____

Date of Birth _____

1
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent_____

Relation _____

Date of Birth _____

2
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

3
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

4
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

5
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

6
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of the Dependent----------

Relation----------

Date of Birth----------

7
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of the Dependent----------

Relation----------

Date of Birth----------

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/-(does not exceed Rs. 9000/-per month).

3. That my son/daughter is unemployed and wholly dependent on me. Note: - The age limit for dependence (**Son-** Till he starts or attains the age of 25 years, whichever is earlier / **Daughter**- Till she starts earning or get married. Irrespective of age limit, whichever is earlier/ **Son suffering from any permanent disability of any kind physical or mental (proof of Disability certificate)** - Irrespective of age limit.)

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 department, DUSIB.

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

Place..... Signature of the applicant .....

Date..... Name & Designation .....

FOR USE IN THE ESTABLISHMENT SECTION/DDOs WHERE THE PF & SB ARE MAINTAINED

The information furnished by the applicant against Column 1 to 14 and details of the dependant family members is verified from the PF & SB and found is correct.

Signature

DA

FORM – B

DELHI URBAN SHELTER IMPROVEMENT BOARD

Application Form for Medical Identity Card for DUSIB Pensioners

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

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

1. Name of Retired Employees (In capital)

   _____

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 preceding retirement: (Encl: Last Pay certificate/Slip)

Pay Band ---------- Grade pay_____Basic pay with matrix level --------

Retired employee's pension---------- PPO No. _____

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 _____

Declaration

I solemnly declare and undertake that: 1. I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Spouse _____

Relation _____

Date of Birth _____

1
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent_____

Relation _____

Date of Birth _____

2
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

3
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

4
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

5
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/-(does not exceed Rs. 9000/-per month).

3. That my son/daughter is unemployed and wholly dependent on me. Note: - The age limit for dependence (**Son-** Till he starts or attains the age of 25 years, whichever is earlier / **Daughter-** Till she starts earning or get married. Irrespective of age limit, whichever is earlier/ **Son suffering from any permanent disability of any kind physical or mental (proof of Disability certificate)** - Irrespective of age limit.)

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 department, DUSIB.

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

9. That I shall deposit my contribution by the 5th of April each year (on financial year basis) regularly failing which I may lose the benefits under the scheme.

10. That I also undertake to submit a declaration of my dependents by the 5th April each year.

Place..... Signature of Retired Employees .....

Date..... Name & Designation .....

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.				

Signature of Retired Employees----------

FOR USE IN THE ESTABLISHMENT SECTION/DDOs WHERE THE PF & SB ARE/WAS MAINTAINED

The information furnished by the applicant against Column 1 to 14 and details of the dependant family members is verified from the PF & SB and found is correct.

Signature

DA

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

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

1. Name of Family Pensioner (In capitals)

_____

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 (Encl- Last pay certificate/Slip):

Pay Band---------- Grade pay----------

Pay with Matrix Level (as per 7th CPC) ----------

(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 and undertake that: 1. I have the following legal dependent(s) whose photograph(s) is/are affixed below:-

Name of Spouse _____

Relation _____

Date of Birth _____

1
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent_____

Relation _____

Date of Birth _____

2
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

3
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

Date of Birth----------

4
PASTE
PASSPORT
SIZE PHOTO
OF 3.5 X 4.5 cm

Name of Dependent----------

Relation----------

5
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/-(does not exceed Rs. 9000/-per month).

3. That my son/daughter is unemployed and wholly dependent on me. Note: - The age limit for dependence (**Son**- Till he starts or attains the age of 25 years, whichever is earlier / **Daughter**- Till she starts earning or get married. Irrespective of age limit, whichever is earlier/ **Son suffering from any permanent disability of any kind physical or mental (proof of Disability certificate)** - Irrespective of age limit.)

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 department, DUSIB.

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

9. That I shall deposit my contribution by the 5th of April each year (on financial year basis) regularly failing which I may lose the benefits under the scheme.

10. That I also undertake to submit a declaration of my dependents by the 5th April each year.

Place..... Signature of Family Pensioner .....

Date..... Name & Designation .....

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.				

Signature of Retired Employees/ family pensioner----------

FOR USE IN THE ESTABLISHMENT SECTION/DDOs WHERE THE PF & SB ARE/WAS MAINTAINED

The information furnished by the applicant against Column 1 to 14 and details of the dependant family members is verified from the PF & SB and found is correct.

Signature

DA