



**FAMILY DECLARATION FORM
FOR CONTRIBUTORY MEDICAL SCHEME (CMS)
IEST, SHIBPUR**

1. Name of the Employee : _____
2. Designation : _____
3. Pay-Band & (Academic) Grade Pay : _____
4. Employee Code : _____
5. Residential Address : _____

6. Blood Group : _____
7. Date of Superannuation : _____
8. Contact No : _____
9. e-mail : _____

<u>Sl. No.</u>	<u>Name of dependent</u>	<u>Relationship with employee</u>	<u>Date of Birth</u>	<u>Blood Group</u>	<u>Remarks/ Health Record Book No.</u>
1.					
2.					
3.					
4.					
5.					
6.					

10. No. of Dependents : _____
11. Health Record Book No. : _____

Documents submitted to ensure the eligibility of the dependents as per CGHS rules. :-

- a.**
- b.**
- c.**
- d.**
- e.**
- f.**

12. Are all the persons whose names are given above are dependant upon you and are residing with you

? **YES / NO.**

(Please attach proof of their staying with you, like copy of Ration Card/ EPIC / Passport/ Identity Card issued by College/School/University / Bank Pass Book etc.)

I undertake to intimate to the IEST, Shibpur, authority immediately if there is any change in dependency criteria of my family members included in this application form. If I fail to intimate and if the IEST, Shibpur, authority comes to know of the change then the facility of CMS scheme is liable to be withdrawn by the IEST, Shibpur, authority and the IEST, Shibpur, authority will be free to initiate any action against me;

I undertake to surrender the CMS Health Record Book on my leaving the Office on termination, resignation, or on ceasing to be eligible for CMS benefits;

I certify that the information furnished by me in this application has been verified to be correct and that no information has been concealed or has been misrepresented and I stand by the same.

Encl:

- Proof of Residence/stay of dependents
- Proof of age of son/dependent brother
- Disability certificate, if age of son is above 25 years.

Date:

Signature of the employee