

ANNEXURE 'A'

DETAILS OF DEPENDENTS AS DEFINED VIDE  
OFFICE ORDER NO.13 DATED 16.7.1999

NAME	AGE	DATE OF BIRTH (Please attach documentary evidence)	RELATION	IS/SHE AVAILING MEDICAL FACILITY OF CGHS OR ANY OTHER INSTITUTION	IS HE/SHE COVERED UNDER ANY MEDICAL CLAIM POLICY	IS HE/SHE RESIDING WITH YOU
1	2	3	4	5	6	7

Date:

Signature of the Employee

ANNEXURE 'B'

DETAILS OF INCOME OF SPOUSE IF HE/SHE IS  
SELF-EMPLOYED OR EMPLOYED ANYWHERE ELSE

NAME OF THE ORGANISATION (IN CASE EMPLOYED)	NATURE OF JOB (IN CASE SELF EMPLOYED)	DATE/YEAR OF JOINING THE ORGANISATION/SELF EMPLOYED (BUSINESS/AGENT)	MONTHLY INCOME
1	2	3	4

- i) Basic
- ii) ADA
- iii) HRA
- iv) CCA
- v) Other All.
- vi) Medical All.
- vii) Commission/  
Profit
- viii) Perks/Receipt  
in lump sum  
(if any)
- ix) Total

Date:

Signature of the Employee

DETAILS OF DEPENDENT OF THE EMPLOYEES  
FOR LTC/MEDICAL BENEFITS

1. NAME & DESIGNATION OF THE EMPLOYEE :
2. PLACE OF POSTING :
3. DETAILS OF DEPENDENT : DETAILS BE FURNISHED IN ANNEXURE 'A'
4. IN CASE OF SPOUSE BEING : SELF EMPLOYED OR EMPLOYED ANYWHERE ELSE. DETAILS BE FURNISHED IN ANNEXURE 'B'

I hereby declare that the statements/details furnished in the enclosed Annexure 'A' & 'B' are true to the best of my knowledge and belief.

DATE:

SIGNATURE OF THE EMPLOYEE