CMS ID: CMS-201

Office of
CONTRIBUTORY MEDICAL SCHEME
IIEST, Shibpur, Howrah

FAMILY DECLARATION FORM

1. Name :_____

2. Designation :_____ 3. Department:_____

4. Pay Band :_____ 5. (Academic) Grade Pay :_____

6. Employee Code :_____7. Gross Salary : _____

8. Contact No. : _____ 9. Blood Group:_____

10. Date of Birth :_____11. Date of Superannuation:_____

12. Residential Address :_____

_____

_____

13. Email :_____

14. Dependant's Declaration:

Sl. No.	Name(s)	Relationship with the Employee	Date of Birth	Blood Group	Residing with the Employee ? (Y / N)
a.					
b.					
c.					
d.					
e.					
f.					

15. No. of Dependents:

16. No. of Health Record Books:

17. Declaration :

I do hereby declare to intimate the Institute-authority immediately if any change in dependency criteria of my family members, mentioned in this application form, occurs.

If I avail myself of the CMS facility for the dependant who is no more my dependant, suppressing the fact, I will be liable to accept any administrative action against me.

I do hereby declare 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 do hereby certify that the information furnished by me in this application is true to the best of my knowledge and belief. No information is concealed or misrepresented.

Date:

_____
Signature of the Employee

Enclo: (Please use √ mark where applicable)

- Proof of residence / stay of dependants (Ration Card/ EPIC / Passport / Bank Pass Book / Identity Card issued by College / school/University etc.)
- Proof of age of son /dependant brother
- Disability certificate, if age of son is above 25 years
- Self certified copy of blood group report.