

Dated :-

Sr. Chief Manager (Personnel)

18-A, DDA SCO Complex,

Defence Colony,

New Delhi-110024

SUBJECT :- APPLICATION FORM FOR ISSUANCE OF MEDICAL CARD

S. No.	Particulars	Information to be filled by the Applicant	
1.	Name of the Applicant		
2.	Entitlement		
3.	Father's Name		
4.	Mother's Name		
5.	Category (Working or Retired)		
6.	Designation		
7.	Current Pay Band with Basic Pay & Grade Pay of Employees (For retired as on date of retirement)		
8.	Residential Address		
9.	Telephone No. (Mobile/Land Line)		
10.	E-Mail ID, If any		
11.	Date of Superannuation (Date/Month/Year)		
12.	Are you on Deputation (Yes/No), If yes, likely date of completion of Deputation		
13.	Date of One Time Contribution (For retired employees only)	Amount (In Figures) (In words) Cheque No./Date Drawn on	
14.	Valid Upto		
15.	Name of Dependent Family Member	Relationship with Employee	Date of Birth (Date/Month/Year)
I.		Self	
II.			
III.			
IV.			
V.			
VI.			
16.	Are all person whose names given above dependent upon you and are residing with you?(Yes/No) (Please attach proof of their Date of Birth and proof of staying with you, like copy of Ration Card/Election ID/Aadhar Card/Passport/Identity		

	Card issued by College/School/University/Bank Pass Book, etc.	
17.	Paste one Stamp Size Photograph of each dependent member of family (including self), separately, whose names are proposed to be included as part of your family in the space given below. Write their names/relationship below the pasted photo	

S.No.1	S.No.2	S.No.3
S.No.4	S.No.5	S.No.6

To be verified by the Dealing Assistant and Concerned Officer.

Verified Dealing Assistant :- _____
 Verified by Concerned Officer :- _____

I undertake of intimate of Personnel Division, DTTDC immediately if there is any charge in dependency criteria of my members include in this application form. If I fail to intimate and if the DTTDC comes to know of the charge then the Medical Facility is liable to be withdrawn by the Corporation and the corporation and/or Appropriate Authority will be free to initiate any action against me.

I undertake to surrender the Medical Card on my leaving the DTTDC on Deputation, Retirement, Termination, Resignation or on ceasing to be eligible for Medical 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.

Name & Signature of the Applicant

E.Code No.

Place of Posting.....

Encl. Proof of Residence

Proof of age of dependents/disability certificate (if any)

One each stamp size photograph of each family member in addition to already photos affixed above.

Copy of the Retirement order/Last pay Drawn. (For retired employees only)