DECLARATION FOR MEDICAL CLAIMS

FORM - 4

राष्ट्रीय डिज़ाइन संस्थान असम
National Institute of Design Assam

Name of the employee : .....

Designation : .....

Dept. / Section / Centre : ..... Emp ID : .....

I, Dr. / Mr. / Ms ..... do hereby declare that I have the following family member(s), who are wholly dependent on me for the purpose of Medical claims and Reimbursement as indicated below. Please go through the relevant rules of dependency for Medical Purpose.

Sl. No.	Name(s)	Relationship	Whether residing with or not	Whether Married / Unmarried / Widow	Date of Birth / Age	Whether employed, pensioner, businessman or others	Monthly income from all sources

I solemnly affirm that all above declarations are true and I understand that in the event of any of the above declarations being found to be incorrect, I shall be liable to disciplinary action as per CCS Conduct Rules / Institute rules in place. Further I undertake to update the above declarations as and when the status changes.

Place : _____

Date : _____

Signature of the employee