



भारतीय प्रौद्योगिकी संस्थान मद्रास , चेन्नै 600 036  
 INDIAN INSTITUTE OF TECHNOLOGY MADRAS, Chennai 600 036  
 Estate Section / Administration III  
 दूरभाष/ Tel. : [044] 2257 8120 फ़ैक्स / Fax: [044] 2257 0509  
 ईमेल/E-mail : mediinsurance@iitm.ac.in



**FORM FOR AVAILING THE MEDICAL FACILITY FOR DEPENDANTS  
 BIO-DATA FORM**

<u>Details of Employee</u>		Photo of Employee
Employee Name :		
Employee ID No.:		
Desig. / Dept. :		
DOB :	DOJ :	
Blood Group :	Marital Status : Unmarried / Married	
Residential Address :		
Contact No. :		
<b>If married, Details of Spouse</b>		Photo of Spouse
Name :		
Date of Birth :		
Employed :	Yes / No	
<b>If yes, details of Employer</b>		
Name of the Employer :		
Address of the Organization :		
<p><i><b>Note :</b> In case the spouse is employed, a certificate from the employer stating that (a) the person concerned is not availing the medical facilities of the employer, or (b) the employer doesnot provide any medical facilities, or (c) the salary package of the person concerned does not include any medical allowances.</i></p>		

**DECLARATION FOR AVAILING MEDICAL FACILITIES (FOR EMPLOYED SPOUSE)**




I ..... employed in the Office of the ..... as ..... do hereby declare that, I opt to avail Mediclaim Insurance and other medical facilities in respect of ourselves and our family members by one of us namely, ..... and we further declare that henceforth Medical facilities will not be availed by ..... from his / her office i.e .....  
 .....

(Signature)  
 Name :  
 Designation :  
 Organisation :



**DECLARATION ACCEPTED**

Signature of Head of Organisation  
 With Seal and Date.




**Details of Children:**

		
Name :	Name :	Name :
Sex :	Sex :	Sex :
DOB :	DOB :	DOB :
Studying / Employed / Unemployed Married / Unmarried	Studying / Employed / Unemployed Married / Unmarried	Studying / Employed / Unemployed Married / Unmarried

**Details of Parents(In case of Female Employee either Parents or Parents-In-Law) :**

	
Name :	Name :
Sex :	Sex :
DOB :	DOB :
Monthly Income : /month	Monthly Income : /month

**Details of Siblings (Brother(s) / Sister(s):**

		
Name :	Name :	Name :
Sex :	Sex :	Sex :
DOB :	DOB :	DOB :
Studying / Employed / Unemployed Married / Unmarried	Studying / Employed / Unemployed Married / Unmarried	Studying / Employed / Unemployed Married / Unmarried

I \_\_\_\_\_, hereby declare as follows;

1. Dependents as stated above are residing with me and are wholly dependent upon me and the total monthly income of my Father/Mother does not exceed Rs.9,000/- per month(*Note-Income limit per month is Rs.9,000/- (Excluding Dearness Relief admissible) and above will not be considered as dependant of the employee.*)
2. The residency proof of my parents,sons(s), daughter(s), brother(s)& sister(s) is also attached herewith.
3. The particulars of dependent members as given above are correct.
4. If any statement is found to be untrue, I shall be liable for disciplinary action.

Date :

Signature of the Staff Member

*The dependants declared by the individual are as per the data available in the Service records(As per CMA rule). The Bio-data form is forwarded to CMO, Institute Hospital for inclusion in the Hospital records, for treatment.*

Date :

**Assistant Registrar (Admn. III)**