INDIAN INSTITUTE OF TECHNOLOGY ROORKEE

MEDICAL FACILITIES AFTER RETIREMENT OF THE EMPLOYEES (MEDIFARE) SCHEME

MEMBERSHIP-CUM-OPTION FORM FOR REGULAR EMPLOYEES

(For all serving regular employees of the Institute who are on the rolls of the Institute on 01.04.2007 or thereafter)

Employee No _____

1. Name of employee : _____
2. Designation :_____ Department/Centre/Unit : _____
3. Date of Birth :_____
4. Entitled Family Member : **(a) Details of living Spouse** **(b) Handicapped dependent Children, if any**

   Name : _____ _____

   Date of Birth : _____ _____

   Relationship : _____ _____
5. Present Address : _____

   _____ PIN _____
6. e-mail ID (if any) : _____
7. Telephone/Mobile No :_____/(Mob.) _____
8. Name & address of Bank (Same as for salary): _____
9. Bank A/c No. (Same as for Salary): _____

I,(name)_____,working in the Institute on the post of _____ hereby opt for Medical Facilities after Retirement to the Employees of the Institute (MEDIFARE) Scheme. I have read the terms of references and other details of the MEDIFARE Scheme contained in the Notification No._____ dated _____, which are acceptable & binding to me. I also agree to abide by for any change/ or modification in the Scheme. Accordingly, I hereby authorize the A.R. (Finance) to deduct the monthly contribution w.e.f. 1st August 2007 from my salary and agree to pay the balance lumpsum amount in 01/02/03/04 equal installments within a year as per column (9 of the Option From given in ***Annexure –A***. I am also enclosing herewith the draft of the balance amount as per detail given below:

P.T.O.

Amount Rs._____ Draft No. _____ Dated _____

Drawn on _____ Payable to_____

Photograph (Self)	Photograph (Spouse)	Photograph (Handicapped child)
Self	Spouse	(Handicapped Child)

Signature _____

Name _____

Date _____

Place _____

For the Use of Establishment 'A'/'B'

Checked & found correct/noticed following shortfall.

Dealing Assistant **Superintendent Estt.(A)/Estt.(B)** **Assistant Registrar Services**

Forwarded to Hospital/Accounts Section

Asstt. Registrar (Medifare Cell)

Annexure-A

OPTION-FORM

I, (name)_____ wish to pay my total contribution as in column-9 in lumpsum ☐ or installments ☐ of one/two/three/four as under:
(select any one of the four)

Medifare: Calculation of Number of Installments and amount of installment

Sl. No.	Employee Group as defined in Clause III-1 of Medifare Scheme Tick () as applicable	Rates of Monthly Subscription (in Rs.)	No. of installments for 20 years (12 months x 20 years)	Total contribution required from each employee (in Rs.)	Date of Retirement (to be given by employee) DD/MM/YY	Remaining service period in months on last day of retirement (to be calculated from 31st Aug. 2007) (Fill 'O' if already retired before this date)	Shortfall in months (240 months – no of months of remaining service) (4-7)	Balance amount to be paid (in case the remaining service is less than 240 months) at the time of option. (8 x 3) To be paid in maximum 4 equal installments within a year
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	A	150	240	36000				
2	B	100	240	24000				
3	C	70	240	16800				
4	D	40	240	9600				

Note: if already retired or the remaining period of service is less than 20 years, deposit of atleast one installment alongwith Membership-cum-Option form is compulsory.

(Signature of the Employee/Pensioner)

Employee/Pensioner No……