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 : _____ Date of Joining : _____

4. Probation period : From _____ To _____

5. Entitled Family Member : **(a) Details of living Spouse** **(b) Handicapped dependent Children, if any**

   Name : _____ _____

   Date of Birth : _____ _____

   Relationship : _____ _____

6 Present Address : _____

   _____ PIN _____

7. e-mail ID (if any) : _____

8. Telephone/Mobile No : _____ /(Mob.) _____

9. Name & address of Bank (Same as for salary): _____

10. 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 Medifare Booklet, 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 from my salary and agree to pay the balance lump sum amount in four equal installments.

P.T.O.

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)