WUS HEALTH CENTRE
UNIVERSITY OF DELHI
DELHI-110007

Application form of membership of WUS Health Centre (Permanent/Adhoc/Temp./Retired Employees) and Addition of the Name of Dependent(s)

The Chief Medical Officer
WUS Health Centre,
University of Delhi, Delhi-110007

Token Card No. _____
Dated _____

Sir,

I, (……..) intend to avail the medical facilities of the W.U.S. Health Centre of University of Delhi. I carefully read and understand the following conditions for availing the medical facilities :

1. I undertake that me and my dependent family member(s) are not availing any medical facilities of any other W.U.S. Health Centre.
2. I also undertake that following family members are totally dependent on me and the monthly income from all sources of each member does not exceed Rs. 9000/- p.m. plus dearness relief at the time of availing the membership of the W.U.S. Health Centre.
3. I also undertake that as per CGHS rules, whenever any of the family member become ineligible for the health centre membership due to marriage/death/earning (whether Government or Private Organization)/attaining the age of 25 years, I shall inform to the W.U.S. health centre in writing and surrender the Health Centre booklet of concerned member (s).
4. I also undertake that I shall deposit the amount of recovery/difference of Health Centre Contribution to the account of the University of Delhi due to implementation of pay commission/deputation/pay upgradation or otherwise.
5. I also undertake that I shall obtain **"No Dues Certificate"** from WUS Health Centre at the time of retirement/deputation/ withdrawal of membership.
6. I also undertake that I agree to abide by the rules which may be amended by the Executive Council from time to time.
7. I am responsible for ensuring the monthly deduction of Health Centre contribution from my salary.
8. In the event of non-compliance of these rules, membership may be terminated anytime and action deemed fit may be initiated against me.

Applicant's Name (in block letters) ……..……..…Age…..... Date of Birth…… Gender…….
Designation……Department/College……..……..……Date of appointment……..
Date of Retirement/Death/VRS…… Residential Address……..……...
…….....Permanent Address……...
…….....……..……..……..Mobile No…….

S.No.	Name of Dependent Member(s)	Date of Birth	Age	Relation	Marital Status	Monthly Income
				Self		

Above particulars are verified from Service Records

Sig. with Seal of Establishment Branch **Applicant's Signature**

(To be filled in by the Office of the Applicant)

This is to certify that as per service record, Dr./Smt./Sh…….. is drawing Basic Pay/Last Pay Drawn .....in the Pay Level.....Cell……..... and above particulars filled by the applicant are correct to the best of my knowledge and belief. The Health Centre contribution will be deducted from the salary of the applicant Rs. …….p.m. w.e.f…… and remitted to the University on monthly basis.

Sign. with Seal of the HOD/Principal of College/Establishment

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(For the use of W.U.S. Health Centre)

Chief Medical Officer **Section Officer** **Dealing Assistant**

Enclosures:

1. Copy of Retirement Orders/PPO/No Dues Certificate issued by W.U.S. Health Centre (only for Retired employees).
2. Copy of AADHAR Card/Birth Certificate/10th School Certificate for the dependent beneficiaries.
3. Disability certificate of child issued by Competent Medical Authority, if applicable.
4. Certificate from the department of spouse (whether Government or Private Organization) that s/he is not availing any medical facilities from her/his office (If spouse is working).
5. Affidavit for dependent member(s) to certify that she/he/they are unmarried, unemployed and totally dependent upon employee on Rs. 10/- stamp paper (non-judicial), whenever applicable.
6. Copy of the payment receipt of prescribed fee. (payment is to be made on University website fee.du.ac.in).

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Token Card No. _____
Dated : _____

Paste ONE Photograph of each family member in the space given below (including self) and attach ONE Photograph of each family member for booklet:

Attested by Head of the Department/ Principal with Seal	*Attested by Head of the Department/ Principal with Seal*	*Attested by Head of the Department/ Principal with Seal*
Name of Applicant (Self) _____	Name _____ Relation _____	Name _____ Relation _____
Attested by Head of the Department/ Principal with Seal	*Attested by Head of the Department/ Principal with Seal*	*Attested by Head of the Department/ Principal with Seal*
Name _____ Relation _____	Name _____ Relation _____	Name _____ Relation _____
Attested by Head of the Department/ Principal with Seal	*Attested by Head of the Department/ Principal with Seal*	*Attested by Head of the Department/ Principal with Seal*
Name _____ Relation _____	Name _____ Relation _____	Name _____ Relation _____

Signature of Applicant