BITS, PILANI- K. K. BIRLA GOA CAMPUS

DECLARATION OF DEPENDENTS FOR REIMBURSEMENT OF MEDICAL CLAIMS

Date_____

I, Prof/Dr/Mr/Ms._____GPSRN_____

hereby declare that, I am residing in Qr. No._____ / I am residing at (address)_____

_____ and that the below mentioned

members of my family are residing with me:

S.No.	Name of Family Member*	Relationship (W/H/S/D/F/M)#	Date of Birth	Whether residing with employee (Y/N)	Whether employed (Y/N)	If yes, mention annual income

* Fully dependent family members of the staff such as non-earning spouse, non-earning/retired parents (in-laws in case of married lady staff) and children are eligible for medical reimbursement.
# W – wife; H – Husband; S – son; D – daughter; F – father; M – mother.

I may be permitted to submit claims for reimbursement as per rules of the Institute for medical reimbursement during the current year 2009 – 10. I undertake to update information as and when necessary and assume responsibility for its veracity from time to time.

_____
Signature of Employee

(For office use)

Information as above is verified. Health Card may be issued to S. Nos._____ with validity.

_____
Deputy Registrar

To

In-charge, Audio-Visual

Health Card(s) issued.

S.No.	Helath Card No.	S.No.	Health Card No.	S.No.	Helath Card No.	S.No.	Health Card No.

Forwarded to General Administration.

In-charge, Audio-Visual