DEPENDENCY DECLARATION FOR THE PURPOSE OF LTC AND TRANSFER BENEFITS

1. NAME _____ DESIGNATION _____ EMP. NO. _____
2. HUSBAND/FATHER'S NAME _____
3. DEPARTMENT _____
4. DETAILS OF DEPENDENTS :

SR.NO.	NAME OF THE DEPENDENT	DATE OF BIRTH	RELATIONSHIP WITH THE EMPLOYEE	RESIDENTIAL ADDRESS	TOTAL INCOME FROM ALL SOURCES	REMARKS/DOCUMENTS SUBMITTED

I hereby declare that :

1. My spouse is not employed / self-employed / retired
2. My spouse is employed with _____ (name of the company) which is a Govt. / Semi Govt. / Public Sector Undertaking / Private Sector Organisation and LTC facility has not been availed of by him / her separately for himself / herself. In support of this claim I am submitting a letter obtained from his / her Office.
3. My spouse is employed in IOC/IOC Group Companies / IOC Joint Venture Companies Viz. _____ since _____ and his / her employee number is _____
4. I also declare that my parents who are dependent on me are actually staying with me under the same roof and their combined monthly income is not more than Rs.3,000/- from all sources, and he* / she / they is / are not getting / availing the facility from any other source.
5. I declare that in case of any change in the particulars given above, I will inform the Corporation immediately. I understand that I shall be responsible in the event the declaration is found false.

Signature of the Employee :

Countersignature of Controlling Officer :
(in Grade 'E' & Above)

Date:

Designation :

* Strike out whichever is not applicable

DEPENDENCY DECLARATION FOR THE PURPOSE OF MEDICAL REIMBURSEMENT

1. NAME _____ DESIGNATION _____ EMP. NO. _____
2. HUSBAND'S/FATHER'S NAME _____
3. DEPARTMENT _____
4. PRESENT ADDRESS _____
5. DETAILS OF DEPENDENTS :

SR.NO.	NAME OF THE DEPENDENT	DATE OF BIRTH	AGE	RELATIONSHIP WITH THE EMPLOYEE	RESIDENTIAL ADDRESS	TOTAL INCOME FROM ALL SOURCES	REMARKS/DOCUMENTS SUBMITTED

1. I declare that my parents who are wholly and exclusively dependent on me and are permanently residing with me under the same roof and he/she/they have no source of income or their combined monthly income is not more than Rs.9,000/- from all sources, and he* / she / they is/are not getting / availing medical reimbursement/facility from any other source.

2. I declare that in case of any change in the particulars given above, I will inform the Corporation immediately. I understand that I shall be responsible in the event the declaration is found false.

Signature of the Employee :

Countersignature of Controlling Officer :
(in Grade 'E' & Above)

Date:

Designation :

* Strike out whichever is not applicable

Note:

1. **If the dependent parents are away for temporary periods, i.e. the limit for which is three months in a financial year, Medical Section has to be informed in writing in advance. If the period is exceeding three months in a financial year, medical reimbursements will not be made for such parent/s. Similarly, if the dependent members are staying away, the same may please be informed to Medical Section immediately. In both the above cases, the employee has to certify the same while submitting medical claim.**

2. **Details of family retention approval to be given wherever applicable.**