



**WUS HEALTH CENTRE
UNIVERSITY OF DELHI
DELHI-110007**

Application form of membership of WUS Health Centre (Permanent/Adhoc/Temp./Retired Employees)/Addition of the Name of Dependent(s)
The Chief Medical Officer/Medical Administrator
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 have carefully read and understood the following conditions for availing the medical facilities.

I undertake:

1. that I and my dependent family member(s) are not availing any medical facility of any other W.U.S. Health Centre.
2. that following family members are totally dependent on me and the monthly income from all sources of each member does not exceed Rs. 9,000/- (Rupees nine thousand only) per month plus Dearness Allowance at the time of availing the membership of the W.U.S. Health Centre.
3. 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 the W.U.S. Health Centre in writing and surrender the Health Centre booklet of the concerned member (s).
4. that I shall deposit the amount of recovery/difference of Health Centre Contribution (HCC) due to implementation of Pay Commission/Deputation/pay upgradation to the account of the University of Delhi.
5. that I shall obtain "No Dues Certificate" from WUS Health Centre at the time of withdrawal of membership/deputation/retirement.
6. that I agree to abide by the rules which may be amended by the Executive Council of the University from time to time.
7. that I shall be responsible for ensuring the monthly deduction of HCC from my salary.
8. that in the event of non-compliance of these rules, my membership may be terminated at 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**.....
.....**Cell No**.....

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

Certified that above particulars have been verified from the Service Records

Signature with Seal of Establishment Branch

Applicant's Signature

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

Certified that as per service record, Sr. Prof./Prof./Dr./Smt./Sh..... is drawing Basic Pay/Last Pay Drawn.....in the Pay Level.....Cell.....and above particulars filled by the applicant have been verified from the service records and are correct to the best of my knowledge and belief. The HCC will be deducted from the salary of the applicant @ Rs.per month/mensem w.e.f.....and remitted to the University on monthly basis.

Signature with Seal of the HOD/Principal of College/Establishment

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

Dealing Assistant

Section Officer

Chief Medical Officer/Medical Administrator

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/10thSchool 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 facility from her/his office (If spouse is working).



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Kindly, paste 01 (one) Photograph of each family member in the space given below (including self) and attach 01 (one) Photograph of each dependent family member for pasting on the W.U.S. Health Centre booklet:

*Attested by Head
of the Department/
Principal with
Seal*

Name of Applicant (Self)

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

*Attested by Head
of the Department/
Principal with
Seal*

Name _____
Relation _____

Signature of Applicant