

**Instruction for payment of Life time contribution at the time of Retirement / Death.**

1. **Whether spouse is working in SAC / ISRO or not, If yes than**  
**Name of employee:**  
**Designation:**  
**P.R. No :, Division :**
2. You are required to specially opt for the Life Time Scheme. Without your option, your family will not be eligible for coverage under the Scheme in the event of your unfortunate death.
3. You should pay the amount of cintribution in advance for ten years.  
(i.e. 129 time of th last month CHSS contribution)
4. While the general definition of ‘family’ applies to you, the coverage will be restricted to the family members covered under the Scheme prior to your retirement, and you will not be allowed to add any new beneficiary.
5. You are required to take medical attendance and treatment only the CHSS station of your choice and not in the palces, including the station where you are residing.
6. You will not be eligible for any travelling allowance for availing medical facilities from the sattion where you are residing to the CHSS station for availing specialized treatment in an outside hospital/institution.
7. Surrender the CHSS cards of any of your family members when he/she becomes ineligible for coverage under the scheme.
8. You are required to give a declaration at the begining of every calander year about the residency and dependancy of the family memers covered under the Scheme and also their non-receipt of any medical facilities from any other source.

**Date:**

**(Sign. of Employee)**

**Encl:** The following documents should be attached invariably.

1. **Cheque / Demand Draft** in favour of “ **Accounts Officer SAC**”
2. **Pay slip** of previous month of **Superannuation/VR.**
3. **Two passport size photographs** of each beneficiaries.
4. **Photo copy of Bank pasbook** first page - 02 copies.
5. Dully filled up retirement form. The individual should have to **fill Form No. 2 in duplicate** as it is mandatory.
6. Exisitng CHSS card(s) to be submitted while applying for life time scheme.

अंशदायी स्वास्थ्य सेवा योजना  
CONTRIBUTORY HEALTH SERVICE SCHEME  
विकल्प प्रपत्र / OPTION FORM

(सेवा निवृत्ति के पश्चात अंस्वासेयो प्राप्त करने हेतु / For availing CHSS after retirement )

1. मैं अपनी सेवानिवृत्ति के पश्चात अं. स्वा. से. यो. सुविधा को जारी रखना चाहता हूँ और मैं ऐतद्वारा अं. स्वा. से. यो. के आजीवन अंशदान का विकल्प देता हूँ | मैं ..... रु. की राशी का भुगतान करना चाहता हूँ |  
I would like to continue to avail the CHSS facilities after my retirement and hereby opt for **Life time contribution** of CHSS. I am willing to pay an amount of Rs. .... ( In words..... )

अथवा /OR

2. मैं अपनी सेवानिवृत्ति के पश्चात अं. स्वा. से. यो. की सुविधाओं को वार्षिक अंशदान के भुगतान के साथ जारी रखना चाहता हूँ |  
I would like to continue to avail the CHSS facilities after my retirement with annual payment of CHSS contribution.

अथवा / OR

3. मैं अपनी सेवानिवृत्ति के पश्चात अं. स्वा. से. यो. की सुविधाओं को जारी नहीं रखना चाहता हूँ |  
I do not want to continue to avail CHSS facilities after my retirement.  
मैं जानता हूँ की अभी दीया गया विकल्प अंतिम होगा और इसे परिवर्तित नहीं किया जा सकता |  
I understand that option exercised now will be final and cannot be changed

हस्ताक्षर / Signature:

नाम / Name : ..... वेतन

अनुक्रमांक सं / PR No. : .....

सेवानिवृत्ति की तिथि / date of Retirement : .....

सेवानिवृत्ति के समय पदनाम / Designation at the time of Retirement: .....

आवसीय पता / Residential Address:

फोन नं / Phone No (M). :.....

सेवा में / To : प्रशासन अधिकारी / Administrative Officer, SAC

अं. स्वा. से. यो. ( सैक ) / CHSS (SAC)

**Form of Option for Life time membership under CHS Scheme in  
respect of retired/retiring employees of DOS/ISRO vide Office  
Memorandum No. D11011/3/2010-Sec.IV Date 11 मार्च, 2010**

I hereby opt for Life Time membership under CHS Scheme. Following are my details:

1.	Name and Designation at the time of retirement			
2.	P.R. No			
3.	Date of Retirement			
4.	Nature of Retirement	<b>Voluntary / Superannuation / Death</b>		
5.	Centre at the time of Retirement			
6.	Basic pay at the time of Retirement	रु.		
7.	Rate of monthly contribution	रु.		
8.	Period of Payments already made	..... से ..... तक		
9.	Payment now being made 1. 10 years – remaining period	FROM.....To.....		
10.	Deatils of the payment made	Cheque No.:      Date: रु.      Enclosed		
11.	Deatils of faimily members covered under CHSS	नाम	आयु	संबंध
		1.		
		2.		
		3.		
		4.		

I request that Life tile CHSS cards to me and family may pleased be issued.

Date: (Signature)

Ahmedabad नाम / Name:

**Full Address :**

फोन नं. (1) ई-मेल / E-mail :

(2) मॉबाईल / Mobile :

Form of option for Life time membership, duly filled in all respect of above retireed employee is received in CHSS Section on .....

**Signature:**

**Name :**

अं.वि./ इसरो के सेवानिवृत्त / सेवानिवृत्त हो रहे मर्मचारियों के लिए कार्यालय जापन सं.  
डी 11011/3/2010-एसईसी.IV दिनांक 11 मार्च, 2010 द्वारा सीएचएसएस योजना के  
अधिन आजीवन सदस्यता के विकल्प फार्म

मैं एतद्वारा सीएचएसएस योजना के अधीन आजीवन सदस्यता का चुनाव करता हूँ | मेरा विवरण निम्नानुसार है :

1.	सेवानिवृत्ति के के समय नाम एवं पदनाम			
2.	वेतन अनुक्रमांक सं.			
3.	सेवानिवृत्ति की तिथि			
4.	सेवानिवृत्ति का प्रकार	स्वैच्छिक / अधिवर्षिता		
5.	जिस केन्द्र से सेवानिवृत्त हुए उसका नाम			
6.	सेवानिवृत्ति के समय मूल वेतन	रु.		
7.	मासिक अंशदान की दर	रु.		
8.	पहले किये जा चुके भुगतान की अवधि	..... से ..... तक		
9.	अब किया जा रहा भुगतान (अ) १० वर्ष -शेष अवधि	.....से ..... तक		
10.	अब किये गए भुगतान का विवरण	चेक नं : ..... दिनांक रु. .... के लिए संलग्न		
11.	सीएचएसएस के अधिन समविष्ट परिवार के आश्रित सदस्यों का विवरण	नाम	आयु	संबंध
		1.		
		2.		
		3.		
		4.		

मैं अनुरोध करता / करती हूँ कि कृपया मेरे और मेरे परिवार के लिए आजीवन सीएचएसएस कार्ड जारी किए जाएं |

दिनांक: ..... (हस्ताक्षर)

अहमदाबाद नाम :

पूरा पता :

फोन नं. (1) ..... ई-मेल E-mail: .....

(2) मॉबाईल (M): .....

उपर्युक्त सेवानिवृत्त कर्मचारी का पूर्ण रूप से भरा हुआ आजीवन सदस्यता के लिए विकल्प का फार्म सीएचएसएस अनुभाग में ..... को प्राप्त हुआ |

हस्ताक्षर:

नाम :

भारत सरकार / Government of India  
अंतरिक्ष उपयोग केंद्र / Space Applications Centre  
अहमदाबाद / Ahmedabad

सेवानिवृत्त कर्मचारियों द्वारा दिया जाने वाला वचन-पत्र  
**UNDERTAKING TO BE GIVEN BY RETIRED EMPLOYEE**

मैं \_\_\_\_\_ के ~~पूर्वाह~~/अपराह को स्वैच्छिक रूप से / अधिवर्षिता पर सेवानिवृत्त हो रहा हूँ। मैं एतद्वारा वचन देता हूँ कि मैं व्यापार / व्यवसाय /युति या सरकारी रोजगार या अन्यथा निजी रोजगार में नियोजित होने पर यथासमय इसकी सूचना कार्यालय को सूचित करूँगा।

I am retiring from the service Voluntarily / on Superannuation with effect from ....., (FN/AN). I hereby undertake that I shall inform to the office regarding my engagement in the trade/business/profession or employment under any Government or otherwise private as and when such events occurs.

आवासिय पता Residential Address:

हस्ताक्षर / Signature:.....

नाम / Name : .....

पदनाम / Designation : .....

वेतन अनुक्रमांक / P.R. No. : .....

फोन नं. / Ph No. & M : .....

अंस्वासेयों सं. /CHSS No. : .....

SPACE APPLICATIONS CENTRE  
ACCOUNTS AND FINANCE SECTION  
SAC P.O. AMBAWADI VISTAR P.O.  
AHMEDABAD- 380 015

DATED: \_\_\_\_\_

TO  
**ACCOUNTS OFFICER (CHSS)**  
ACCOUNTS, SAC  
**2045 / 46 /47**

SUB: TRANSFER OF CHSS BILLS PAYMENTS IN **STATE BANK OF INDIA**  
.....**BRANCH**  
**AHMEDABAD -380 .....**

Sir,

I REQUEST YOU TO TRANSFER MY CHSS BILLS PAYMENTS FROM THE MONTH OF  
..... ONWARDS TO

**STATE BANK OF INDIA .....** **BRANCH, AHMEDABAD-380 .....**

MY **STATE BANK OF INDIA SAVING ACCOUNT NO.** IS :  
.....

THANKING YOU,

SIGNATURE	: .....
NAME	: .....
PAY ROLL NO.	: .....
DESIGNATION	: .....
DIVISION	: .....
TELEPHONE NO	: .....
MOBILE	: .....

(Copy of pass-book 1<sup>st</sup> page ( 2 COPIES) should be attached.)

PASSPORT SIZE  
PHOTO OF THE  
BENEFICIARY  
AFFIX  
HEREWITH  
(SELF)

**सीएचएसएस फॉर्म CHSS Form 2**

PASSPORT SIZE  
PHOTO OF THE  
BENEFICIARY  
AFFIX HEREWITH  
(SPOUSE)

**भारत सरकार / GOVERNMENT OF INDIA  
अंतरिक्ष विभाग / DEPARTMENT OF SPACE  
अंतरिक्ष उपयोग केंद्र / SPACE APPLICATIONS CENTRE  
अहमदाबाद / AHMEDABAD**

**अंशदायी स्वास्थ्य सेवा योजना / CONTRIBUTORY HEALTH SERVICE SCHEME**

**हिताधिकारियों के नाम जोड़ने हेतु आवेदन पत्र / Application for addition of names of beneficiaries including self**

नाम / Name : .....

पदनाम / Designation : .....

डिस्पेंसरी/ अचिअ / Dispensary/AMO : .....

निवास का पता / Residential Address : .....

फ़ोन नं. / Telephone No. : (o) ..... (M) .....

**संमिलित किए जाने वाले हिताधिकारियों का विवरण/ PARTICULARS OF BENEFICIARIES TO BE INCLUDED**

Sl. No.	Name	Nationality	Relationship	Date of Birth	Occupation, if any	Income if any, p.m.	Marital Status / Remarks
1.							
2.							
3.							
4.							
5.							

मैंने पिछले भाग में दिये गए निर्देशों को सावधानीपूर्वक पढ़ लिया है तथा उसका अर्थ समझ लिया है। मैं प्रमाणित करता हूँ कि उपरोक्त दर्शाये गये व्यक्ति निर्धारित शर्तों को पूर्ण करते हैं तथा वे सीएचएसएस के आधिन पंजीकृत होने के पात्र हैं।

I have read the instructions on the reverse side very carefully and have understood their meaning. I certify that the persons mentioned above fulfil the conditions prescribed and they are eligible for registration under CHSS.

मैं यहां आश्वासन देता हूँ कि प्रत्येक कैलेंडर वर्ष के प्रारंभ में तथा इसके पश्चात भी पात्रता अथवा मेरे एवं मेरे अभिभावक/परिवार के सदस्यों जिजिके नाम ऊपर दर्शाए गए हैं के सीएचएसएस लाभ के बारे में जबभी आवश्यक होगा तब यथाशीघ्र घोषणा देता रहूँगा। मेरा यह उत्तरदायित्व होगा कि जब भी उपरोक्त में से कोई व्यक्ति सीएचएसएस लाभ प्राप्त करने हेतु अयोग्य हो जाए तब इसकी सूचना सीएचएसएस अनुभाग को दूँ तथा उस हिताधिकारी का सीएचएसएस कार्ड आवश्यक रूप से जमा करा दूँ। मुझे यह ज्ञात है कि योजना का लाभ प्राप्त करने के लिए उपरोक्त दर्शाये गए सदस्यों की पात्रता साबित करने का दायित्व मुझ पर निर्भर है।

I hereby undertake to declare at the beginning of each calendar year and as soon as necessary thereafter about the eligibility or otherwise to the CHSS benefits of myself and my parents / family members whose names are mentioned above. It shall be my responsibility to notify the CHSS Section when any person referred to above becomes ineligible to the CHSS benefits, and shall promptly deposit the CHSS cards of such beneficiaries. I realise that the onus of proving eligibility of the members mentioned above to the benefits of the scheme rests on me.

कृपया पुत्र, पुत्री भाई एवं बहन के मामले में वैवाहिक स्थिति दर्शाएं।

Please indicate marital status in the case of son, daughter, brother and sister.

**माता-पिता के संबंध में प्रमाणपत्र / Certificate in respect of parents**

मैं प्रमाणित करता हूँ कि ऊपर दर्शाए गए मेरे माता-पिता मुख्यतः मुझ पर आश्रित हैं और मेरे साथ ही रहते हैं | I certify that my parents whose names are mentioned above are mainly dependent on and residing with me.

Date : To:

**Signature**

प्रशासन अधिकारी ,सीएचएसएस  
Administrative Officer, CHSS

**Instructions of the employees**

1. The term 'Parents' for the purpose of CHSS benefits does not include 'step parents' parents should have actually resided at least for 60 days with the employee before they are proposed for inclusion under the CHSS, and should continue to reside with the Government Servant and be mainly dependent on him. If the total income of the parents from all sources does not exceed the pay of the Government Servant, subject to the maximum income of the parents being Rs.18000/- per month, such parents may be treated as mainly dependent on the Government Servant. Income from land holdings, houses, fixed deposits, dividends, securities, deposits, employment, pension etc., should be taken into account for the purpose of the total income of both the parents. If the parents of an employee move out for more than 60 days continually, the CHSS Section should be notified by the employee for suspension/cancellation of CHSS facilities. The CHSS cards shall also be promptly deposited with the Administration.
2. Only unmarried dependent children are eligible for CHSS benefits. Married daughters of employee, though dependent on the employee are not eligible for medical benefits under CHSS. In the case of adopted children, only legally adopted sons and daughters are eligible for the benefits of the CHSS.
3. If any of the family members/dependents for whom the registration is sought is eligible to receive medical aid/facility, cash subsidy, cash allowances or reimbursement for medical care from sources other than the CHSS of DOS, particulars of such benefits should be furnished on a separate sheet.
4. If any of the members of the family proposed for registrations is engaged in trade/business or is employed outside the DOS on part/full time basis, full particulars of such occupation should be furnished on a separate sheet duly supported by documentary evidence so that their legibility for CHSS benefits could be determined.
5. Employees giving false or misleading information will be liable for disciplinary action.

**FOR USE IN CHSS SECTION**

सीएचएसएस कार्ड नं. / CHSS Card No. \_\_\_\_\_

प्रभाव से सम्मिलित / Added with effect from:

दिनांक Date:

**Admn. Officer (CHSS)**

प्राप्त / Received CHSS Cards. \_\_\_\_\_

दिनांक/ Date:

**Signature of the employee**



**भारत सरकार / GOVERNMENT OF INDIA**  
**अंतरिक्ष विभाग / DEPARTMENT OF SPACE**  
**अंतरिक्ष उपयोग केंद्र / SPACE APPLICATIONS CENTRE**  
**अहमदाबाद / AHMEDABAD**

**अंशदायी स्वास्थ्य सेवा योजना / CONTRIBUTORY HEALTH SERVICE SCHEME**  
**हिताधिकारियों के नाम जोड़ने हेतु आवेदन पत्र / Application for addition of names of beneficiaries**

नाम / Name : .....

पदनाम / Designation : .....

डिस्पेंसरी/ अचिअ / Dispensary/AMO : .....

निवास का पता / Residential Address : .....

फ़ोन नं. / Telephone No. : (o) ..... (M) .....

**संमिलित किए जाने वाले हिताधिकारियों का विवरण / PARTICULARS OF BENEFICIARIES TO BE INCLUDED.**

Sl. No.	Name	Nationality	Relationship	Date of Birth	Occupation, if any	Income if any, p.m.	Marital Status/ Remarks
1.							
2.							
3.							
4.							
5.							

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मैं यहां आश्वासन देता हूँ कि प्रत्येक कैलेंडर वर्ष के प्रारंभ में तथा इसके पश्चात भी पात्रता अथवा मेरे एवं मेरे अभिभावक/परिवार के सदस्यों जिजिके नाम ऊपर दर्शाए गए हैं के सीएचएसएस लाभ के बारे में जब भी आवश्यक होगा तब यथाशीघ्र घोषणा देता रहूँगा। मेरा यह उत्तरदायित्व होगा कि जब भी उपरोक्त में से कोई व्यक्ति सीएचएसएस लाभ प्राप्त करने हेतु अयोग्य हों जाए तब इसकी सूचना सीएचएसएस अनुभाग को दूँ तथा उस हिताधिकारी का सीएचएसएस कार्ड आवश्यक रूप से जमा करा दूँ। मुझे यह ज्ञात है कि योजना का लाभ प्राप्त करने के लिए उपरोक्त दर्शाये गए सदस्यों की पात्रता साबित करने का दायित्व मुझ पर निर्भर है।

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कृपया पुत्र, पुत्री भाई एवं बहन के मामले में वैवाहिक स्थिति दर्शाएं।

Please indicate marital status in the case of son, daughter, brother and sister.

**माता-पिता के संबंध में प्रमाणपत्र / Certificate in respect of parents**

मैं प्रमाणित करता हूँ कि उपर दर्शाए गए मेरे माता-पिता मुख्यतः मुझ पर आश्रित हैं और मेरे साथ ही रहते हैं | I certify that my parents whose names are mentioned above are mainly dependent on and residing with me.

Date:

To:

**Signature**

प्रशासन अधिकारी, सीएचएसएस

The Administrative Officer, CHSS

**Instructions of the employees**

The term 'Parents' for the purpose of CHSS benefits does not include 'step parents' parents should have actually resided at least for 60 days with the employee before they are proposed for inclusion under the CHSS, and should continue to reside with the Government Servant and be mainly dependent on him. If the total income of the parents from all sources does not exceed the pay of the Government Servant, subject to the maximum income of the parents being Rs.18000/- per month, such parents may be treated as mainly dependent on the Government Servant. Income from land holdings, houses, fixed deposits, dividends, securities, deposits, employment, pension etc., should be taken into account for the purpose of the total income of both the parents. If the parents of an employee move out for more than 60 days continually, the CHSS Section should be notified by the employee for suspension/cancellation of CHSS facilities. The CHSS cards shall also be promptly deposited with the Administration.

1. Only unmarried dependent children are eligible for CHSS benefits. Married daughters of employee, though dependent on the employee are not eligible for medical benefits under CHSS. In the case of adopted children, only legally adopted sons and daughters are eligible for the benefits of the CHSS.
2. If any of the family members/dependents for whom the registration is sought is eligible to receive medical aid/facility, cash subsidy, cash allowances or reimbursement for medical care from sources other than the CHSS of DOS, particulars of such benefits should be furnished on a separate sheet.
3. If any of the members of the family proposed for registrations is engaged in trade/business or is employed outside the DOS on part/full time basis, full particulars of such occupation should be furnished on a separate sheet duly supported by documentary evidence so that their legibility for CHSS benefits could be determined.
4. Employees giving false or misleading information will be liable for disciplinary action.

**FOR USE IN CHSS SECTION**

सीएचएसएस कार्ड नं. / CHSS Card No. \_\_\_\_\_

प्रभाव से सम्मिलित / Added with effect from:

दिनांक Date:

**Admn. Officer (CHSS)**

प्राप्त / Received CHSS Cards. \_\_\_\_\_

दिनांक/ Date:

**Signature of the employee**

અહમદાબાદ - 380 015. / AHMEDABAD - 380 015.

PASSPORT  
SIZE PHOTO  
OF THE  
BENEFICIARY  
AFFIX HEREWITH

अंशवासेयो / अंउके  
CHSS/SAC  
फार्म-8  
Form-8  
केसवृत्त  
Case History

जन्मतिथि / Date of Birth \_\_\_\_\_

पंजीकरण संख्या  
Registration  
Number

वेतन अनुक्रमांक  
Pay Roll No.

वेतन बैंड में वेतन Pay in the Pay Band	Rs.
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दिनांक Date	रोग विषयक निदान और निष्कर्ष Clinical findings and diagnosis	उपचार Treatment

दिनांक Date	रोग विषयक निदान और निष्कर्ष Clinical findings and diagnosis	उपचार Treatment

અહમદાબાદ - 380 015. / AHMEDABAD - 380 015.

PASSPORT  
SIZE PHOTO  
OF THE  
BENEFICIARY  
AFFIX HEREWITH

अंशवासेयो / अंउके  
CHSS/SAC  
फार्म-8  
Form-8  
केसवृत्त  
Case History

Name of the beneficiary \_\_\_\_\_

पंजीकरण संख्या  
Registration  
Number

Relationship &amp; Name of the employee \_\_\_\_\_

वेतन अनुक्रमांक  
Pay Roll No.

रक्त वर्ग / Blood Group :

वेतन बैंड में वेतन  
Pay in the Pay  
Band

जन्मतिथि / Date of Birth

दिनांक Date	रोग विषयक निदान और निष्कर्ष Clinical findings and diagnosis	उपचार Treatment

