

**INDIAN INSTITUTE OF TECHNOLOGY ROORKEE**  
**MEDICAL FACILITIES AFTER RETIREMENT OF THE EMPLOYEES (MEDIFARE) SCHEME**  
**MEMBERSHIP-CUM-OPTION FORM FOR REGULAR EMPLOYEES**

(For all serving regular employees of the Institute who were on the rolls of the Institute on  
 21<sup>st</sup> September 2001 or thereafter)

Employee No. \_\_\_\_\_

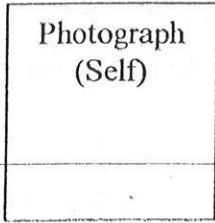
1. Name of employee : \_\_\_\_\_
2. Designation : \_\_\_\_\_ Department/Centre/Unit \_\_\_\_\_
3. Date of Birth : \_\_\_\_\_
4. Entitled Family Member
 

	(a) Details of living Spouse	(b) Handicapped dependent Children, if any
Name	: _____	: _____
Date of birth	: _____	: _____
Relationship	: _____	: _____
5. Present Address : \_\_\_\_\_  
 \_\_\_\_\_ PIN \_\_\_\_\_
6. e-mail ID (if any) : \_\_\_\_\_
7. Telephone/Mobile No. : \_\_\_\_\_/(Mob.) \_\_\_\_\_
8. Name & address of Bank (Same as for salary): \_\_\_\_\_
9. Bank A/c No. (Same as for salary) \_\_\_\_\_

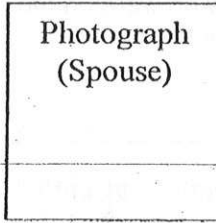
I, (name) \_\_\_\_\_, working in the Institute on the post of \_\_\_\_\_ hereby opt for Medical Facilities after Retirement of Employees (MEDIFARE) Scheme. I have read the terms of references and other details of the MEDIFARE Scheme contained in the Notification No. \_\_\_\_\_ dated \_\_\_\_\_, which are acceptable & binding to me. I also agree to abide by for any change/or modification in the Scheme. Accordingly, I hereby authorize the A.R.(Finance) to deduct the monthly contribution w.e.f. 1<sup>st</sup> August 2007 from my salary and agree to pay the balance lumpsum amount in 01/02/03/04 equal installments within a year as per column (9) of the Option Form given in **Annexure-A**. I am also enclosing herewith the draft of the balance amount as per detail given below :

Amount Rs \_\_\_\_\_ Draft No \_\_\_\_\_ Dated \_\_\_\_\_

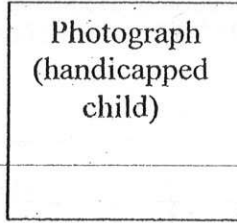
Drawn on \_\_\_\_\_ Payable to \_\_\_\_\_



Self



Spouse



(Handicapped Child)

Signature \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Place \_\_\_\_\_

---

For the Use of Establishment 'A'/B'/Pension Cell

Checked & found correct/noticed following shortfall.

**Dealing Assistant**

**Superintendent**

**A.R./D.R.**

---

Forwarded to Hospital/Accounts Section/Medifare Cell

**Asstt. Registrar (Medifare Cell)**

## OPTION-FORM

I, (name) \_\_\_\_\_ wish to pay my total contribution as in column-9 in lumpsum  or installments  of one/two/three/four as under:(select any one of the four)

## Medifare: Calculation of Number of installments and amount of installments

Sl. No.	Employee Group as defined in Clause III-1 of Medifare Scheme Tick ( ) as applicable	Rates of Monthly Subscription (in Rs.)	No of installments for 20 years (12 months x 20 years)	Total contribution required from each employee (in Rs.)	Date of Retirement (to be given by employee) DD/MM/YY	Remaining service period in months on last day of retirement ( to be calculated from 31 <sup>st</sup> Aug 2007) (Fill 'O' if already retired before this date)	Shortfall in months (240 months- no of months of remaining service) (4-7)	Balance amount to be paid (in case the remaining service is less than 240 months) at the time of option. (8 x 3). To be paid in maximum 4 equal installments within a year. (9)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	A	150	240	36000				
2	B	100	240	24000				
3	C	70	240	16800				
4	D	40	240	9600				

Note: If already retired or the remaining period of service is less than 20 years, deposit of atleast one installment alongwith Membership-cum-Option Form is compulsory.

(Signature of the Employee/Pensioner)  
Employee/Pensioner No. ....