

FORM-C

CONTRIBUTORY SCHEME FOR POST RETIREMENT MEDICAL FACILITIES

MEDICAL CARD

REGISTRATION NO. ....  
(To be filled in by the Registering Office)

1  
Space for  
Affixing  
Photographs of  
Beneficiaries

2  
Space for  
Affixing  
Photographs of  
Beneficiaries

- I. Name of the retired employee and employee number :
- 2. Date of retirement :
- 3. Designation at the time of retirement :
- 4.. Scale of pay and basic pay on the date of retirement :
- 5. Project Office from which retired :
- 6. Project/Office where registered for medical benefits under the scheme :
- 7. Permanent Address :
- 8. Present Address :
- 9. Validity period of the card :

**NAME OF THE BENEFICIARIES**

- (i) ..... (Retired employee) ..... (age)
- (ii) ..... (Spouse) ..... (age)

Specimen signature of the  
retired employee.

Signature of the issuing officer

Specimen signature of beneficiary's spouse

Date of issue

Designation

**DETAILS OF THE CONTRIBUTION PAID**

Sl. No	Period for which paid From To	Rate per month	Total contribution paid	Card valid upto	Date, stamp signature of the receiving officer