ANNEXURE-- 'A'

APPLICATION FORM FOR JOINING THE V.O. CHIDAMBARANAR PORT TRUST EMPLOYEES (CONTRIBUTORY OUT- DOOR AND IN- DOOR MEDICAL BENEFIT AFTER RETIREMENT) REGULATIONS,1996.

Affix Single/Joint Photo

1	**Name of the Retire/ Deceased Employee (In Block Letters)**			
2	**a) Designation & Class of Post**			
	b) Staff No /P.P.O.No			
	c) Department			
3	**Date (i) Appointment**			
	(ii) Retirement / Death			
4	**Last Pay Drawn**	**Rs.**		
5	**Nameof the Surviving Wife/ Husband**			
	Name	**Relation**	**Date of Birth**	**Present Age**
	(i)			
	(ii)			
6	**Name of the Applicant**			
7	**Permanent Address**			

(Signature of the Applicant)

"I have personally verified the contents of the application with reference to the records available with this Department and it is certified that the Applicants is eligible for the benefit under the V.O.Chidambaranar Port Employees (Contributory Out - door and In – door Medical Benefit after retirement) Regulations,1996."

HEAD OF DEPARTMENT

To
THE CHIEF MEDICAL OFFICER / VOCPT

ANNEXURE-- 'B'

V.O. CHIDAMBARANAR PORT TRUST EMPLOYEES (CONTRIBUTORY OUT -DOOR AND IN - DOOR MEDICAL BENEFIT AFTER RETIREMENT) REGULATIONS, 1996:

IDENTITY CARD NO

1	Name of the Retire / Deceased Employee	
2	Name of the Surviving Wife / Husband	
3	Designation on the date of Retirement with Name of Department and Staff No / P.P.O.No	
4	Date of Retirement / Death	
5	Last Pay Drawn	RS.
6	Rate of Contribution	
7	Marks of Identification - Self	i)
		ii)
	Wife	i)
		ii)
8	Particulars of Payment	
	i)	
	ii)	
	iii)	
9	Signature of Retired Employee / Applicant	
10	Signature of Head of the Department with Rubber Stamp	

ANNEXURE-- 'C'

DECLARATION TO BE FILLED IN AT THE TIME OF JOINING THE TUTICORIN PORT TRUST EMPLOYEES (CONTRIBUTORY OUT -DOOR AND IN - DOOR MEDICAL BENEFIT AFTER RETIREMENT) REGULATIONS, 1996 AND THEREAFTER ON 1ST APRIL OF EVERY YEAR :

FOR PENSIONERS:

I, the Undersigned ……..
Wife/Husband of …….. Staff No……
Designation……..of……..Department retired from the Service of the Board with effect from……do hereby declare that I am / I am not employed in any Public or Private Sector Undertaking and I am not covered by any Medical Benefit Scheme by such Employer.

FOR FAMILY PENSIONERS

I, the Undersigned ……..
Wife/Husband of (late)…….. Staff No……
Designation……..of……Department ……..expired during the service of Board on……do hereby declare that I am / I am not employed in any Public or Private Sector Undertaking and I am not covered by any Medical Benefit Scheme by such Employer.

I .D. Card No …… Issued by……

SIGNATURE