

**BOSE INSTITUTE
KOLKATA**



Photograph of the Dependant (Passport size)

DEPENDENT DECLARATION FORM FOR MEDICAL CLAIM

(to be submitted separately for each dependant)

1. Institute ID No :
2. Name :
3. Department/Division :
4. Pay Band :
5. Pay in Pay Band :
6. Grade Pay :
- 7. NAME OF THE DEPENDANT :**
(in Block Letters) For MEDICAL
BENEFITS ONLY
8. DOB of the Dependant :
(Attach Proof)
9. Relationship of the Dependant
with the employee :
- 10. Whether the Dependant residing
with the employee (yes/no) :**
(Attach Proof)
11. If no, Address of the Dependant :

12. Profession of the Dependant :
13. Monthly/Annual Income of the
Dependant (From all sources) :
14. PAN Number of the Dependant :
(for 18 years and above)

I, hereby declare that the statement furnished above is true in all respect to the best of my knowledge and **I also declare that any changes in the above statement that will occur in any subsequent date will be brought to the knowledge of the Bose Institute Authority (Director/Registrar) immediately.**

SIGNATURE OF THE EMPLOYEE

SIGNATURE OF THE DEPENDANT
(to be made by the employee, if minor)