

#### **CONTRIBUTORY MEDICAL SCHEME**

# FORM OF DECLARATION

|  |  |
| --- | --- |
| Staff Name : |  |
| Designation : |  |
| CMS Regn. No.  |  |
| Spouse Name : |  |
| Spouse employment details : |  |
| Whether the spouse is availing any medical benefits from his/her employer in the form of allowance/reimbursement/insurance. |  |
| Please specify the benefits |  |

I hereby declare that the above information are true to the best of my knowledge and belief.

Date: Signature of Staff Member

 Administrative Officer