



Saha Institute of Nuclear Physics

1, AF, Bidhannagar, Kolkata-700 064.

OPTION FORM FOR AVAILING MEDICAL BENEFITS

For Ph.D. Students (Research Fellows-JRFs & SRFs)

A. PARTICULARS OF THE STUDENT/RESEARCH SCHOLAR

1. Name (in Block Letters): _____
2. Student/Registration ID: _____
3. Department/Division/Section: _____
4. Programme :
☐ Junior Research Fellow ☐ Senior Research Fellow ☐ Other (Specify) : _____
5. Date of Joining: _____
6. Fellowship/Stipend (per month): ₹ _____
7. Residential Address:

8. Mobile No.: _____
 9. E-mail ID: _____
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B. EXERCISE OF OPTION : *Please tick (✓) either Option-I or Option-II or Option-III [for SELF ONLY].*

In accordance with the Institute's policy regarding medical benefits for Ph.D. Students (RFs), I hereby exercise my option by selecting at least **ONE** of the following Options :

[Note : Students who have insurance policy can also opt for the Medical Scheme of SINP].

OPTION-I

(i) Existing Medical Benefit Scheme of the Institute (FOR SELF ONLY) :

☐ I hereby opt to become a beneficiary under the **Existing Medical Benefit Scheme of the Institute.**

I voluntarily authorize the Institute to deduct **1% (One per cent)** of my monthly fellowship/stipend towards contribution to the Existing Medical Benefit Scheme, as prescribed by the Institute from time to time.

I understand that the contribution shall continue until I cease to be associated with the Institute or until otherwise decided under the Institute's policy.

OPTION-II

(ii) Personal Health Insurance Policy (FOR SELF ONLY) :

☐ I do **not** wish to become a beneficiary under the Existing Medical Benefit Scheme of the Institute. Instead, I undertake to maintain, at my own cost, a **Personal Health Insurance Policy with a minimum sum insured of ₹3,00,000/-** (Rupees Three Lakh only) **per annum / for each policy period throughout my tenure / association with the Institute.**

I further undertake that:

1. The insurance policy shall remain valid throughout my association with the Institute, for as long as I remain eligible for and continue to receive the fellowship.
2. The insurance policy shall remain valid throughout my association with the Institute, as long as fellowship is allowed.
3. I shall submit a copy of the valid insurance policy at the time of joining.
4. I shall submit a copy of the renewed insurance policy every year to the concerned Administrative Section **before expiry** of the existing policy.
5. Any change in the insurance policy shall immediately be intimated to the Institute.
6. Failure to maintain a valid insurance policy or failure to submit proof of renewal within the prescribed time may render me ineligible to continue under this option, and the Institute may take such action as may be deemed appropriate under its rules/orders.

OPTION-III : ☐ Both the above options (I) & (II) (FOR SELF ONLY) :

C. DECLARATION

I hereby declare that:

1. I have carefully read and understood the provisions governing both options.
2. The option exercised by me has been made voluntarily and without any coercion.
3. I agree to abide by all rules, regulations, orders and instructions issued by the Institute from time to time relating to medical benefits.
4. I understand that the option once exercised shall ordinarily remain **final during my tenure in the Institute and shall not be changed except with the approval of the Competent Authority or as otherwise provided under the Institute's policy.**
5. I certify that the particulars furnished above are true and correct to the best of my knowledge and belief.

Place : _____

Date : _____

Signature of Student / Research Fellow

Name : _____

D. FOR OFFICE USE ONLY :

Option exercised :

- ☐ **Option-I** : Existing Medical Benefit Scheme of the Institute (FOR SELF ONLY).
- ☐ **Option-II** : Personal Health Insurance Policy (FOR SELF ONLY).
- ☐ **Option-III** : Both the above Options (I) & (II) (FOR SELF ONLY).

In case of Option – II & Option - III :

Insurance Company : _____

Policy Number : _____

Sum Insured : ₹ _____

Policy Valid From : _____ **To:** _____

Copy of Policy / Renewal Submitted : ☐ Yes ☐ No

Checked and Verified by :

Name: _____

Designation: _____

Signature: _____

Date: _____

ESTABLISHMENT OFFICER

REGISTRAR

CC. :

1. Accounts Officer for information and needful pl.
2. IC, Medical Unit for information and needful pl.