INDIAN COUNCIL OF MEDICAL RESEARCH, New Delhi

No.19/06/2022-Estt.
Dated:13/01/2023

CIRCULAR

Sub: - Income Limit of dependent family members for availing CGHS facilities reg.-

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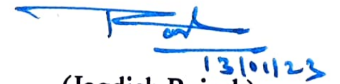
Attention is invited to Govt. Of India, Ministry of Health and Family Welfare (CGHS-P Section)'s O.M. S-11012/2/2016-CGHS-P) dated 8th, November, 2016 on the above mentioned subject. After implementation of 7th CPC, MoH&FW with consultation of Deptt. Of Expenditure has revised the income limit for the purpose of providing CGHS coverage to the dependent family member to Rs.9000/- per month plus the amount of dearness relief.

2. As per CCS(Conduct) Rules every Govt. servant must maintain high ethical standards and honesty but it has come to the notice, that some staff are availing CGHS facility and claiming medical re-imbursement of their dependent family members, who has an earnings of more than Rs.9000/- per month, which is unbecoming of being a Govt. servant.

3. All beneficiaries of CGHS facility are hereby requested to submit an undertaking that the income of their dependent family members does not exceed the ceiling as mentioned above. If it is found that an employee has suppressed or not updated information regarding the earning of his/her dependents necessary disciplinary action will be initiated against him/her. The format of Undertaking is enclosed herewith.

Further, all staff of ICMR Hqrs/NIOP/NIMS/NIMR/NICPR residing in Delhi/NCR has to pay CGHS contribution from the date of their joining, unless they availing medical facility from their spouse's office.

This issues with the approval of Competent Authority.



(Jagdish Rajesh)
Assistant Director General(Admn.)

Director/Director-Incharge,
NIMS, NIOP, NIMR,(Delhi) & NICPR, Noida(For similar action)

Copy to:-

1. PS to DG/Sr.DDG(A)/Sr. F.A
2. All the Staff of ICMR Hqrs Office
3. A.O.(Medical Cell)
4. Guard File

UNDERTAKING

It is certified that as per MOH&FW (CGHS-P Section)'s O.M. No. S-1112/2/2016-CGHS-P dated 8th November, 2016, the details of family members, wholly dependent on me for Medical Aid & LTC is as under:-

Sl. No.	Name	Age	Relationship

I solemnly affirm and declare that all the information given by me in the Undertaking are true and correct to the best of my knowledge and nothing has been concealed therein. If any discrepancy or false information is found in the Undertaking then I shall be liable for all consequential action including disciplinary proceedings.

Signature________________

Name ________________

Place:-

Designation______________

Dated:-

Instt./Centre______________