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| **Undertaking Form****Eklavya Staff Hospitalisation & Medical Assistance Scheme (ESHMAS)** |

I, […………………………………Name of the Eklavya employee], hereby declare and affirm that […...……………………………...] is directly dependent on me for being a [………………………………..........................................................................................................................................................................................................................................................specify the reason how and why s/he is dependent, e.g., unemployed / handicapped/ minor/ retired person with no pension etc.]. The above declaration is as per the guidelines and norms of the ESHMAS.

I acknowledge that any breach of this undertaking may result in disqualification from [EHMAS benefits]. I understand the declaration and commit to its accuracy and honesty. Furthermore, I agree to the following conditions:

1. I will promptly notify Eklavya of any changes in the dependency status of [………………………………Relative's Full Name].
2. I will provide any necessary documentation or evidence to support the dependency claim.
3. I understand that providing false information or failing to disclose changes in dependency status may lead to disciplinary action.

I am aware that signing this undertaking is a binding agreement, and I accept the consequences outlined herein.

Signature: Date:

Staff Member's Full Name:

For Official Records:

Received declaration document on……………………..

Verified by …………………………………………… after EC approval

(Director/ Executive Officer)

Date: