

(Ref: Board's letter No. PC-V/2011/A/Med./1, dated 7-06-2011)

UNDERTAKING FORM

(to be submitted DUPLICATE by pensioners/family pensioners to his/her Pension Disbursing Authority (PDA))/Pension Sanctioning Authority (PSA), Whichever is applicable. PDA should retain one copy of the Undertaking and furnish the other to the PSA for necessary action.)

1. I _____ a retired employee/family Pensioner whose _____ (specify relation of family pensioner with deceased Railway employee) was an employee of (office address) _____ declare that I am residing at (residential address indicated in PPO)

_____ which is beyond 2.5 KMs from the nearest Railway hospital/health unit

_____ (Name of the Hospital/Health Unit as contained in Annexure-III to Railway Board's letter No. PC-V//98/I/7/1/1 dated 21.4.1999.

2. Accordingly I hereby opt to claim Fixed Medical Allowance of Rs. 100 and/or Rs. 300 per month as per prescribed rate. Necessary endorsement may please be made in my PPO in this regard. Simultaneously, I undertake that I will not avail of OPD facilities (except in cases of chronic diseases as mentioned in Board's letter No. 2006/H/DC/JCM, dated 12-10-2006) at Railway hospitals/Health Units from the day I claim Medical Allowance. I also understand that grant of Medical Allowance is subject to the terms and conditions specified in Board's letter No. PC-V/98/I/7/1/1 dated 21.4.99 and 1.3.2004 and last being letter No. PC-V/2006/A/Med/1, dated 15-9-2009.
3. I also declare that I have not availed of any treatment as Out Door Patient (except in cases of chronic diseases as mentioned in Para-2 above) for the period from _____ (indicate here the date of retirement or the date of availing OPD facility on the last occasion or 1.12.1997, whichever is later) to this day _____ (indicate here the date on which this declaration is signed). I may accordingly be paid arrear of Medical Allowance @ Rs. 100 and/or Rs. 300 per month for the period mentioned above as per prescribed rate.
4. The above information furnished by me is correct to the best of my knowledge and belief. I also understand, that, if at any stage, it is found that the undertaking submitted by me is incorrect or carries false

information, my FMA is liable to be stopped with immediate effect and further suitable action could be taken to recover the excess amount paid to me.

Place_____ Signature_____

Date_____ Name of Full_____

PPO No._____

Issued By_____

SB A/C No._____

Post office/Bank_____

Branch_____