HSWS/Form-1A

The Chair,
Health Staff Welfare Scheme (HSWS),
Ministry of Health: Thimphu.

Sub: **Application for HSWS membership.**

Madam/Sir,

1. I, Dr/Mr/Mrs/Ms…… bearing Employee ID……, CID…….. employed under Ministry of Health hereby acknowledge that I have read and fully understood the rules and regulation of the HSWS bylaw.

2. As I wish to become a registered member of the HSWS, I understand that my failure to abide by the HSWS rules and regulation may result in suspension or revocation of membership privileges in accordance to decision of the HSWS Management Board.

3. In Line with the HSWS rules, I hereby agree to deposit my monthly membership subscription Quarterly/Half yearly/Annually to the HSWS corpus, until such time I hold HSWS membership.

Present address	Employment address		
Position Tile		Type of service: **Regular/Contract**	
Dzongkhag		Mobile No	
Email ID			
Permanent Address	Dzongkag	Gewog	Village
Employee Bank account No.		Name of the bank	
Please indicate	☐ New membership	☐ Renewal of existing membership	

I hereby appoint the following as my nominee(s)/additional beneficiary (ies) for the above membership. I further understand that I reserve the right to revoke the nomination of such beneficiaries and substitute any other name thereof and to appoint additional beneficiaries provided in **HSWS form 2.**

……..
Name & Signature of the employee **Date**: ……

DECLARATION OF BENEFICIARIES AND NOMINEE (S) **HSWS FORM- 1B**

I, Dr/Mr/Mrs/Ms…… CID……,do hereby declare the details of my dependents and nominees as below. I request and authorize the HSWS Management Board to distribute any benefit (s) payable in the event of any tragedy covered by HSWS bylaw in accordance with this form.

Sl. No	Name of the direct Dependent(s)	CID No of the dependents	Date of Birth of the dependent	Relationship to HSWS Member
1				
2				
3				
4				
5				
6				
7				

Further I do hereby nominate and confer on Dr/Mr/Mrs/Ms …… CID No…….. the right to receive the entire benefit that may be payable to me by the HSWS in the event of my demise.

I hereby declare that all the information given above are true and correct based on my belief and knowledge. In case any information so provided in this form are found to be false or misleading I shall be liable under the law as deemed proper.

Affix legal stamp

…….. ……
Signature of the employee **Date:**

……..
Full Name of the employee

Verified by……..
(HOD/MS/CMO/Adm.Officer/Incharge)

DECLARATION OF BENEFICIARIES AND NOMINEE (S)

HSWS FORM- 1B

FOR HSWS OFFICE USE ONLY:

Dr/Mr/Mrs/Ms…… Is hereby registered as a HSWS member with effect from …….. he/she has been allocated with HSWS registration No……

……
Name & Signature of HSWS manager
Copy to: MS/CMO/Administrative Officer,…….. for information and record.