

FMA FORM N-1

(For Central Government employees covered under NPS and their family members for availing Medical Facilities under Central Government Health Scheme or Fixed Medical Allowance after retirement/ death)

1.	I reside/will be residing at the following address:-			Passport size photo of the Applicant
	Flat, House No. and Street/Locality			
	Village & PO		City and District	
	State		Pin Code	
2.	No. of years of qualifying service :-			
3.	I opt the following facility (tick in the column applicable below)			
i.	I will be residing in a CGHS area and would be availing CGHS facility			
ii.	I will be residing in a CGHS area but would not be availing CGHS facility. I understand that I will not be eligible for Fixed Medical Allowance (FMA)			
iii.	I will be residing in non-CGHS area but would be availing CGHS facility for In-patient Department (IPD) and Out-patient Department (OPD) treatment. I will not be eligible for FMA			
iv.	I will be residing in a non-CGHS area but would be availing CGHS facility for IPD treatment only by payment of CGHS contributions. I will also avail FMA for OPD treatment.			
v.	I will be residing in a non-CGHS area and would not be availing CGHS facility for both IPD treatment and OPD treatment. I will avail FMA.			
vi.	I will avail medical facilities available to spouse/family a member who is an employee/ pensioner of Government/PSU/Autonomous Body. I will not avail CGHS facility and FMA			
vii.	Avail Medical facility of previous Organisation. I will not avail CGHS facility and FMA			
	Note:- This is my one time change in option as provided in Rules and it supersedes the earlier option given by me. I understand that I shall not be able to change this option again. (Strike out this item if not applicable)			

4. **Details:**

Name of the Retiring Employee/ Family member	
In case of Family member give name of the Government employee:-	
Relationship with Government employee	
Office Address	
Present Residential Address	
PRAN of the Government employee	
Bank Account No.	
Bank Address (Branch Name)	
IFSC Code	

Undertaking

I _____, (a retired employee)*/ [family member of the deceased employee _____, (write name of the deceased employee in case of family member)]* who was working in the office _____ (Complete office Address) declare that I am residing at _____, which area is not covered under CGHS or any corresponding Health Scheme administered by the Ministry /Department _____ (as the case may be). I also have not obtained nor wish to obtain any CGHS card for availing outdoor facilities under CGHS/Corresponding Health Scheme of the other Ministry/Department from any dispensary situated in the adjoining area.

Note: * Strike out whichever is not applicable.

Place:-

Date:-

(Signature of head of office)

(Signature of applicant)