

Government of India
Department of Atomic Energy
General Services Organisation
(DAE Hospital, CHSS Office)

Kalpakkam 603102

Ref: GSO/DECL(2025)/94/CHSS/2776

December 12, 2025

CIRCULAR No.203/CHSS/HOSP

Sub: Declaration for availing CHSS medical facilities for the year 2026 – reg.

As per Para 4.2.1 of CHSS Rule, a declaration regarding **income/residence of parents (parents-in-law in case of female employees)** and also **residence/dependence of eligible children** (above 18 years of age and up to 25 years of age only) who are covered under the CHSS, is to be furnished by all employees concerned for continuation of the medical facilities to them for the year 2026. (Proof for residence is to be furnished). In this connection, the following points may please be noted:

1. Income of dependent parents (of both) or parents-in-law (in case of female employees only) **should not exceed Rs. 9000/- p.m.** from all sources including Pension (before commutation) plus the amount of Dearness Relief (DR) as on the date of consideration. [Pensioners (Parents/In-laws) who are drawing basic pension above Rs.9000/- after the implementation of the 7th CPC recommendations are not eligible for continuation of CHSS facility (DAE OM No. 7/14/2016/IR&W/17165 dated 28.12.2016 may please be referred). A copy of IT Return (**Assessment Year: 2025-2026**) **acknowledgement filed is to be furnished.** However, in exceptional cases, where the submission of the acknowledgement of IT Returns is not possible due to procedural difficulties, employees may furnish a Self-Declaration in the enclosed format for continuing/extending fresh CHSS facilities to such dependents. Employees are advised to submit Self-Declaration only in unavoidable circumstances where filing of IT Return is of not practical. (DAE OM No. 201/127/17/2020/IR&W/Vol.II/7714 dated 10.06.2022).

2. Children (up to 25 years of age) who are unmarried/unemployed are only eligible for CHSS facility and those who are working in private sector/business are not eligible for CHSS facility. In case of part-time employment, their income **should not exceed Rs. 9000/-p.m.** (as per DAE OM dated 08.05.2023). A copy of the income tax return of the previous year (**Assessment Year: 2025-2026**) in respect of dependent wards who are 22 years and beyond, is to be furnished every year for confirmation of income details. However, if the ward is a student attending regular classes in a college and is not pursuing distance education or correspondence course, then **an appropriate document issued by the bonafide/recognized institute** indicating that the dependent ward is pursuing education attending regular classes, **can be submitted in lieu of the income tax return**, apart from a declaration by the employee regarding the ward's income, for availing CHSS facility (DAE Note No. VIG-10/10/2020-DAE/2617 dated 22.02.2022). CHSS facility to children beyond 25 years of age due to medical reasons like physically handicapped/mentally retarded etc. is extended with the approval of DAE subject to fulfillment of prescribed conditions.

In case of failure to renew the medical card, such CHSS beneficiary is not eligible for availing of any CHSS facility. Medical cards of CHSS beneficiaries who are ineligible now (due

to death/crossing of income ceiling limit, age limit of children/employment/marriage etc.) should be surrendered to the CHSS Office, DAE Hospital without fail.

Accordingly, employees concerned are requested to submit a declaration as per the format given below on or before **31.01.2026** to the CHSS Office, DAE Hospital, Kalpakkam 603102 and renew the CHSS cards issued to the CHSS beneficiary before the due date.


(V. Lakshmi Devi) 12/12/25
Assistant Personnel Officer

Encl.: Declaration form

ALL NOTICE BOARDS & ALL EMAIL ID (IGCAR/MAPS/GSO/BARCF/BHAVINI/PRP/CISF/AECS/
DAE Clinic – Pallavaram/IMSc)
Circulation through E-mail.

Copy to:

Administrative officer, IGCAR/GSO/BARCF/PRP/DPS/IMSc.
Manager (HR), MAPS/BHAVINI,
Principal, AECS – I/II/III,
Commandant, CISF, Kalpakkam/BHAVINI.

DECLARATION FOR CONTINUATION OF MEDICAL FACILITIES (FORMAT)

(To be filled in BOLD LETTERS)

YEAR: 2026

CHSS MEDICAL FILE NO.:

UNIT:

1. Name of the Employee:

2. Designation: 3. IC No.: 4. Section.:

5. Pay in the pay matrix: **Pay.:** & **Level :**

6. Intercom No. (Serving employee).: 7. Mobile No.:

8. Email Id:

9. Address.:
.....

10. Details of children above 18 years of age / parents (or parents-in-law in case of female employees only) / spouse working outside DAE requiring continuation of medical facility:

Sl. No	Medical Card Number	Name of the beneficiary	Relationship to employee	Date of Birth	* Income & Medical allowance/ assistance p.m. if any	IT Return filed date (copy attached)

Date:

Signature of the employee

Note: Indicate income from all sources including total pension amount/savings if any.

For Children, indicate course of study, if any.

Action including cancellation of CHSS card (s) will be taken against official concerned in case of suppression of facts or submission of false information in the declaration.

Enclosures: 1. Original CHSS Card (s)
2. Copy of IT acknowledgement (Assessment year: 2025-26)
3. Copy of certificate issued by the Institution as a proof of pursuing studies.
4. Document ascertaining residence proof.

(To be forwarded through Administration)

Date:

Signature with Seal

Self Declaration form to be furnished as per the DAE OM
No.201/127/17/2020/IR&W/Vol.II/7714 dated 10.06.2022

स्व घोषणा Self Declaration

I. कर्मचारी का विवरण Employee Details

01. नाम Name: 02. पदनाम Designation:
03. कर्मचारी सं. Emp. No: 04. सीएचएसएस सं. CHSS No.
05: इकाई Unit: 06: पैन कार्ड सं. Pan Card No:
07. आधार कार्ड सं. Aadhar Card No:
08. राशन कार्ड सं. Ration Card No.:

राशन कार्ड के अनुसार लाभार्थियों की सूची List of beneficiaries as per ration card:

- 1.
- 2.
- 3.

II. आश्रितों का विवरण (प्रत्येक आश्रित के संबंध में पृथक घोषणा) Details of Dependent (Separate Declaration in respect of each Dependent):

- i) नाम Name :
- ii) संबंध Relationship :
- iii) जन्म तिथि Date of Birth :
- iv) आयु Age :
- v) वैवाहिक स्थिति Marital Status :
- vi) अशक्तता (यदि कोई हो तो) Disability (if any) :
- vii) अध्ययनरत हैं अथवा नहीं Whether studying or not :
- viii) पेशा / रोजगार / व्यवसाय Profession/ Employment/ Occupation :
- ix) पत्रव्यवहार का पता Address for Communication :

- x) स्थायी पता Permanent Address :

- xi) मासिक आय Monthly Income :

- xii) वार्षिक आय (संबंधित साक्ष्य की प्रतिलिपि संलग्न करें) Annual Income (Copy of relevant proof to be attached)

पेंशन Pension:

म्यूचल फंड Mutual Fund:

बैंक जमा Bank Deposits:

डाक बचत Postal Savings:

कृषि Agriculture:

किराए से आय Rented Income:

अन्य स्रोत Other Sources :

कुल Total:

- xiii) a) PAN/GST का विवरण PAN/GST Details:

(साक्ष्य संलग्न करें Proof to be attached)

b) यदि उपलब्ध नहीं है तो उसका कारण if not available reason thereof:

- xiv) a) ITR आय प्रमाण पत्र ITR Income Certificate

(साक्ष्य संलग्न करें Proof to be attached)

b) यदि उपलब्ध नहीं है तो उसका कारण if not available, reason thereof :

- xv) a) आधार कार्ड संख्या AADHAR Card Number :

b) यदि उपलब्ध नहीं है तो उसका कारण if not available, reason thereof :

- xvi) बैंक खाते का विवरण (ऐसे सभी खातों का विवरण दें जिसमें आश्रित का नाम प्रथम खाताधारक के रूप में हो) Bank Account details (Provide all available A/c's in which the dependent's name appears as the first account holder)

बैंक का नाम Bank Name	खाता संख्या Account No.	IFSC क्रमांक IFSC No.

(आश्रित के हस्ताक्षर/Signature of the Dependent/
बाएँ हाथ के अंगूठे का निशान/ Left hand thumb impression)

नाम Name:

(कर्मचारी के हस्ताक्षर Signature of the Employee)

नाम Name :

पदनाम Designation:

इकाई Unit:

घोषणा Undertaking

मैं, श्री / श्रीमती _____, पुत्र/पत्नी/पुत्री श्री _____,
आयु _____ निवासी _____, जिला _____, पदनाम : _____,
कार्यालय _____ एतद्वारा घोषणा करता / करती हूँ कि ऊपर दी गई जानकारी और
संलग्न दस्तावेजों में मेरी सर्वोत्तम जानकारी और विश्वास के अनुसार सत्य है और इसमें कुछ भी छिपाया
नहीं गया है। मैं इस तथ्य से भली-भांति परिचित हूँ कि यदि मेरे द्वारा दी गई सूचना असत्य/असत्य सिद्ध
होती है तो मुझे कानून के अनुसार दंड भुगतना होगा। साथ ही, मेरे द्वारा प्राप्त सभी लाभों को पूरी तरह
से वापस ले लिया जाएगा।

I, Shri/Smt. _____, son/ wife/ daughter of Shri _____, age
_____ resident of _____, District _____, designation:
_____ working at office _____ hereby declare that the
information given above and in the enclosed documents is true to the best of my knowledge and
belief and nothing has been concealed therein. I am well aware of the fact that if the information
given by me is proved false/ not true, I will have to face the punishment as per the Law. Also, all
the benefits availed by me shall be summarily withdrawn.

दिनांक Date :

स्थान Place :

आवेदक के हस्ताक्षर Signature of the Applicant

फोन/मोबाइल Phone/Mob. :

ई-मेल e-Mail :

नोट : घोषणा में तथ्यों को छिपाने या गलत सूचना प्रस्तुत करने के मामले में अधिकारी के खिलाफ
सीएचएसएस कार्ड को रद्द करने सहित दंडात्मक / आपराधिक कार्रवाई की जाएगी।

Note: Penal/ Criminal action including cancellation of CHSS Card will be taken against officer in
case of suppression of facts or submission of false information in the Declaration.

CHSS beneficiary card Number: _____

Intercom Phone number: (Office) _____ Residence: _____ (if any)

To

Assistant Personnel Officer (CHSS), DAE Hospital, Kalpakkam 603 102.