

# **Sister Nibedita Government General Degree College for Girls**

**Hastings House, Alipore, Kolkata-27**

## **NOTICE**

Notice No: SNGGDCG/28

Date: 27/05/2021

In continuation to this Office Notice No. 26 dated 15.5.2021, the undersigned wishes to inform you that the process of updating the WBHS details of teaching and non-teaching members of this college is underway. The staff members are advised to ensure that both the incumbent and the beneficiaries have not yet applied for inclusion of their names as beneficiaries under any other Govt Health Scheme offered by Govt. of India/any State Govt./Govt. undertaking/Statutory or Local bodies.

The attached declaration needs to be filled-up and submitted online at the earliest at the mail id **wbhs@snggdcg.ac.in**.

-Sd/-

Dr. Sebanti Bhattacharya  
Officer-in-Charge,  
Sister Nibedita Government General  
Degree College for Girls, Kolkata

**DECLARATION BY INCUMBENT RELATED TO WBHS**

I hereby declare that both myself and the under-noted beneficiaries of my family have not applied for inclusion of our names under any other Govt Health Scheme offered by Govt. of India/any State Govt./Govt. undertaking/Statutory or Local bodies/Educational Institutions, etc.

1. Name of the Incumbent :
2. Name of the Beneficiaries :
  - (a)
  - (b)
  - (c)
  - (d)

Signature of the Incumbent (Employee)

WBHS Application ID:

Date:

**DECLARATION BY BENEFICIARY RELATED TO WBHS**

In case any beneficiary is in service under the Govt. of India/any State Govt./Govt. undertaking/Statutory or Local bodies/Educational Institutions, etc., the following particulars are to be furnished:

1. Name and Address of his/her office :
2. Statement of Non-drawal of Medical Allowance : I do not draw any Medical Allowance  
or Govt. Health Scheme Benefits (Copy of Latest or enjoy any Govt. Health Scheme Benefits  
Pay Slip or Certificate from Competent authority at my parent institution.  
is to be Attached)

I hereby declare that the particulars stated above under Serial Nos. 1 to 2 are true.

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Signature of the Beneficiary

Name:  
Designation:  
Department:  
Office:

Date: