**AFFIDAVIT**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_S/O,D/O,W/O \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CNIC.No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

R/O \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I do hereby solemnly affirm and state as under:

1. That for the purpose of availing Medical Facilities under the Dawood University of Engineering and Technology Karachi Medical Reimbursement Facility for regular employees.
2. I hereby declared that my following family members are wholly dependent upon me and that they normally reside with me.

SN .Full Name S/O,D/O,W/O,H/O CNIC NO. Date of Birth Relationship

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

1. I certify that the monthly pension is not exceeding of Rs. 15,000/- p.m. of any my dependent family member as mentioned above.
2. I certify that my dependent family members as stated above are unemployed/Self-employed and shall not claim Medical benefit from his/her parent employer for himself/herself and members of family.
3. I further certify that my dependent family member as stated above neither dependent on any of my sibling or anybody else nor is covered under any medical claim policy of any my sibling or anybody else’s employer.
4. I certify that my dependent family member as stated above is not covered under any scheme, in which reimbursement of their medical expenses is being made or borne by any authority.
5. I understand that the benefit of medical reimbursement can be claimed in respect of male child up to age of 24 years and for female child till she remains unmarried (In both cases employed children will not be entitled for reimbursement), mentally retarded children for life time or till his/her recovery from illness.
6. I understand that the benefit of medical reimbursement cannot be claimed from two different sources. In this regard, I declare that no medical reimbursement for my dependent family member is being claimed or availed by siblings.
7. I undertake that if there is any change in any of the deposition made above I shall immediately inform about such change, failing which appropriate action may be taken against me.
8. The above statements are absolutely true and I am aware that in the event of my statement found to be false I will be liable to repay the whole amount of medical expenditure claimed along with interest at the company’s borrowing rate p.a. in addition to disciplinary action.

**Sign of Deponent**

**Witness-1 Witness-2**