GOVERNMENT OF GOA,
PUBLIC HEALTH DEPARTMENT
SECRETARIAT, PORVORIM-GOA

No.38/164/2013-I/PHD/ (Part-VII) / 1786 Dated: 18/09/2017

Read: Notification No. 38/164/2013-I/PHD (Part-III) dated 12/12/2016

NOTIFICATION

Government is pleased to further amend the Scheme “Deen Dayal Swasthya Seva Yojana” published in the Official Gazette, Series 1 of No.38 dated 22/12/2016 (hereinafter called “the said scheme” as follows, namely.

In the said Notification, the title of the clause 6 shall be corrected to read as “ADDITIONAL BENEFICIARY & OTHER INFORMATION” and the following sub-clause 6 (i) shall be substituted to read as under:

“Goa Government employees and their dependents that are governed under the existing Medical Attendance Rules shall be entitled to opt for enrollment under the scheme, by giving the required option in the form appended, to be submitted by the concerned employee to his/her Head of Office/Department. Option once exercised shall not be changed for a period of one year”.

This Notification shall come into force with immediate effect.

By order and in the name of the Governor of Goa,

(Maria Seomara Desouza)
Under Secretary (Health-II)

Encl: as above
To,
The Director, Printing & Stationery, Government Printing Press, Panaji-Goa for favour of publication in the Official Gazette.

Copy to:
1. The Director, Directorate of Health Services, Panaji-Goa.
2. The Dean, Goa Medical College, Bambolim-Goa.
3. The Additional Secretary (Finance), Finance Department, Secretariat, Porvorim-Goa
4. The Director of Accounts, Panaji.
5. The Joint Director of Accounts, South Branch, Margao-Goa
7. The under Secretary (Health-I), Secretariat, Porvorim-Goa
8. The Under Secretary (GA-II), GAD, Secretariat, Porvorim –Goa
9. The Head of Office/Department.
10. Guard File
11. O/C
FORM OF OPTION UNDER DEEN DAYAL SWASHTYA SEVA YOJANA
SCHEME FOR GOVERNMENT EMPLOYEE

I hereby opt for enrollment under Deen Dayal Swasthya Seva Yojana Scheme along with my following dependent family members and will not claim under Government medical reimbursement facility.

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<th>Sr. No</th>
<th>Name of family member</th>
<th>Age</th>
<th>Relationship with Government Official</th>
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I declare that option once exercised shall not be changed for a period of one year.

Date:
Place:

Signature:

Name of Government Official
Designation
Name of the Department
To which attached: