

**DECLARATION OF  
DEPENDENTS**

1. I, \_\_\_\_\_ holding Citizenship ID No. \_\_\_\_\_, RCSC Employee ID No. \_\_\_\_\_, Village \_\_\_\_\_ Geog \_\_\_\_\_, Dzongkhag \_\_\_\_\_, do hereby

declare that the names mentioned below are my dependents:

a. Name of Spouse (s):                      1. \_\_\_\_\_                      2. \_\_\_\_\_  
Date of Birth:                                      \_\_\_\_\_  
Citizenship ID No:                                      \_\_\_\_\_

**b. Children:**

i) \_\_\_\_\_ Date of birth: \_\_\_\_\_  
ii) \_\_\_\_\_ Date of birth: \_\_\_\_\_  
iii) \_\_\_\_\_ Date of birth: \_\_\_\_\_  
iv) \_\_\_\_\_ Date of birth: \_\_\_\_\_

c. **Father:** \_\_\_\_\_ Age: \_\_\_\_\_  
Citizenship ID No. \_\_\_\_\_

d. **Mother:** \_\_\_\_\_ Age: \_\_\_\_\_  
Citizenship ID No. \_\_\_\_\_

e. **Father-in-law:** \_\_\_\_\_ Age: \_\_\_\_\_  
Citizenship ID No. \_\_\_\_\_

f. **Mother-in-law:** \_\_\_\_\_ Age: \_\_\_\_\_  
Citizenship ID No. \_\_\_\_\_

2. In the event of their demise, benefits as defined in the MD-SWS bye-laws, may be paid to me.
3. I hereby nominate and confer on \_\_\_\_\_, CID No. \_\_\_\_\_ the right to receive the entire amount that may be payable to me by the MD-SWS in the event of my death.

I hereby declare that the information given above are true and correct and I commit full responsibility thereof and I shall be liable for action as deem fit under the byelaws of MD-SWS (3<sup>rd</sup> Edition July 2023)

Date: \_\_\_\_\_

Affix  
Legal  
Stamp

\_\_\_\_\_  
[Name & Signature]

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Verified by: **Dzongkhag Census Officer**

(Signature, Name & Seal) to be used.

\_\_\_\_\_

\_\_\_\_\_

Approved by: **Staff Secretary**

(Signature, Name & Seal) to be used.

**Benefit Claim & Verification**

**IMPORTANT:** This Form is to be submitted within three months for the release of benefit with a death certificate issued by Hospital / Dzongkhag / Gup.

1. Name of Member: \_\_\_\_\_
2. Present Address : \_\_\_\_\_
3. Village: \_\_\_\_\_ Gewog: \_\_\_\_\_ Dzongkhag: \_\_\_\_\_
4. CID.No: \_\_\_\_\_ Contact # \_\_\_\_\_
5. Claim for (Tick the relevant one below)  
Death of: Spouse / Child / Father / Mother / Father-in-law / Mother-in-law / Member  
Name: \_\_\_\_\_; Age: \_\_\_\_\_ CID No. \_\_\_\_\_
6. Beneficiary Account # : \_\_\_\_\_
7. Document enclosed : [Tick the relevant one]
  - a) Verification Certificate from Gup, OR
  - b) Death Certificate from Dzongkhag, OR
  - c) Death Certificate from Medical Officer
  - d) Marriage Certificate
  - e) Family Tree

I hereby declare that all the information provided here is true and accurate

\_\_\_\_\_  
**Signature of the applicant**

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**Verification by Sector Head**

I hereby declare that information provided by the applicant is true to the best of my knowledge and as per the record maintained in this office.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature with Office seal: \_\_\_\_\_

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**Approved by MD- SWS Staff Secretary**

**Verification for Benefit Claim on Transfer / Resignation / Retirement**

**IMPORTANT:** This Form is to be submitted within three (3) months for the release of benefit with transfer order / relieve order / resignation acceptance order / retirement order issued by the concerned competent authority.

1. Name of Member / Beneficiary: \_\_\_\_\_
2. RCSC EID. No: \_\_\_\_\_; CID No: \_\_\_\_\_
3. Present Address : \_\_\_\_\_
4. Village: \_\_\_\_\_ Gewog: \_\_\_\_\_ Dzongkhag: \_\_\_\_\_
5. Date of Joining MD-SWS: \_\_\_\_\_ Contact #: \_\_\_\_\_
6. Total contribution made from the start to date: \_\_\_\_\_ ( Please use a separate sheet to work out the details).
7. Claim for (Tick the relevant one below)  
  
 Transfer / Resignation / Retirement  
  
 Name: \_\_\_\_\_  
  
 Age: \_\_\_\_\_ Citizenship ID No \_\_\_\_\_,
8. Beneficiary Account # : \_\_\_\_\_
9. Document enclosed : Tick the appropriate one
  1. Resignation acceptance order, OR
  2. Transfer Order, OR
  3. Retirement Order

I hereby declare that all the information provided here is true and accurate

\_\_\_\_\_  
Signature of the applicant

**Verification by Sector Head**

I hereby declare that information provided by the applicant is true to the best of my knowledge and as per the record maintained in this office.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature with Office seal: \_\_\_\_\_

**Approved by MD- SWS Staff Secretary**

**Verification on Medical Benefit Claim**

**IMPORTANT:** This Form is to be submitted before departure or not later than 15 days after the arrival in Bhutan from medical treatment.

10. Name of Member : \_\_\_\_\_
11. RCSC EID. No: \_\_\_\_\_; CID No: \_\_\_\_\_
12. Present Address : \_\_\_\_\_
13. Village: \_\_\_\_\_Gewog: \_\_\_\_\_Dzongkhag: \_\_\_\_\_
14. Beneficiary Account # : \_\_\_\_\_
15. Hospital Referred By: \_\_\_\_\_
16. Country & Hospital Name (Referred To) : \_\_\_\_\_
17. Document enclosed : **Medical referral letter**

I hereby declare that all the information provided here is true and accurate

\_\_\_\_\_  
**Signature of the applicant**

**Verification by Sector Head**

I hereby declare that information provided by the applicant is true to the best of my knowledge and as per the record maintained in this office.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature with Office seal: \_\_\_\_\_

**Approved by MD- SWS Staff Secretary**