

CBT-242
14/01/26



GURU JAMBHESHWAR UNIVERSITY OF SCIENCE & TECHNOLOGY, HISAR-125001

Ref.No./ACs/25/AF2/3276

Dated :08-12-2025

15/1/26
SE

NOTIFICATION

EN-I/EN-II
15/1/26

The Vice-Chancellor, on recommendations of the Medical Committee in its meeting held on 27-10-2025, is pleased to approve that the Faculty and Establish Branch will take fresh dependency affidavit from the Teaching and Non-Teaching staff respectively for reimbursement of medical bills on closing of every financial year i.e. from April to March duly attested from First Class Magistrate.

Further, the Vice-Chancellor is also pleased to approve that an affidavit issued by first class magistrate with the following details should be furnished by the claimant of Teaching and Non-Teaching staff through Faculty and Establish Branch respectively, one time for reimbursement of medical bills as per Haryana Govt. Medical Reimbursement rules with immediate effect:

1. Claimant will furnish an affidavit issued by First Class Magistrate with the following details through Faculty Branch in case of teaching and Estt. Branch in case of non-teaching, one time respectively for reimbursement of medical bills.

Key elements of a medical reimbursement affidavit dependency undertaking form

Personal and patient details: Your name, employee ID, designation, and the name, age, and relationship of the patient for whom expenses were incurred.

Dependent declaration: A statement that the patient relating is wholly dependent on you and their details are in your service book and he/she is residing with you and you had incurred expenditure submitted for reimbursement.

Income proof: A statement that dependent is neither an employee anywhere nor a pensioner and the income from all sources of your parents, wards with age detail, widow sister, Father-in-Law, Mother-in Law etc does not exceed Rs.3500/- per month (except Spouse)

In case spouse is working

- Certified that my wife/husband is not getting any fixed medical allowance from any source.
- Certified that my wife/husband is employed and he/she has not claimed reimbursement of any of these medicines. An affidavit to this effect has been given for claiming the reimbursement claim.

- Certified that I am not an adhoc employee and am working on regular basis.
- Treatment details: Information about the hospital, the dates of treatment, and the diagnosis.
- Declaration of no prior claims: An assurance that you or your dependents are not claiming this reimbursement from any other source including health Insurance etc.
- Agreement for recovery: A statement agreeing that any excess payment can be recovered from you.
- Justification for non-empaneled hospitals: If treatment was received at a non-empaneled hospital, a justification for why it was necessary is often required alongwith emergency certificate.
- Signature: Your signature, date, and place. (Specimen copy of the affidavit is enclosed)
- The Faculty Branch/Estt. Branch may be requested to take a fresh dependency affidavit on closing of every financial year i.e. from April to March.

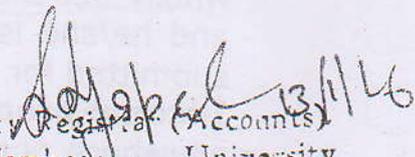
REGISTRAR

Endst. No. ACs/25/AF2/3277-3283

Dated: 08-12-2025

Copy of the above is forwarded to the following for information and necessary action:

1. OSD to Vice-Chancellor, (for kind information of the Vice-Chancellor), GJUS&T, Hisar.
2. Assistant Registrar (Estt.), (with request to endorse the copy of affidavit to all the branch officers), GJUS&T, Hisar
3. Assistant Registrar(Faculty), (with request to endorse the copy of affidavit to all the Dean, Chairpersons & Faculty members), GJUS&T, Hisar.
4. SMO, GJUS&T Hisar
5. Financial Advisor, GJUS&T, Hisar
6. PA to Registrar GJUS&T, Hisar

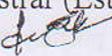

 Deputy Registrar (Accounts)
 Guru Jambhadr University
 of Science Technology, Hisar

(Establishment Branch)

Endst. No. EN-II/2026/ 668-97 Dated: 22/11/26

Copy of the above is forwarded to the following for information and further necessary action:-

1. All Branch Officers, Guru Jambheshwar University of Science and Technology, Hisar.


Assistant Registrar (Estt.)
for Registrar 

AFFIDAVIT AND UNDERTAKING FOR MEDICAL REIMBURSEMENT OF DEPENDENT(S)
HISAR JURISDICTION

AFFIANT IDENTIFICATION AND OATH

I, [FULL LEGAL NAME OF EMPLOYEE/AFFIANT], son/daughter/wife/husband of [FATHER/HUSBAND's/WIFE NAME], Employee ID: [EMPLOYEE ID], Designation: [DESIGNATION/POST], residing at [AFFIANT's FULL RESIDENTIAL ADDRESS], being of sound mind and competent to testify, do hereby solemnly swear or affirm and undertake under penalty of perjury that the following statements relating to the medical reimbursement claim are true and correct to the best of my knowledge, information, and belief.

DEPENDENT AND PATIENT DETAILS

1. The expenses submitted for reimbursement were incurred for the treatment of [FULL NAME OF PATIENT], aged [PATIENT'S AGE] years, whose relationship to me is [RELATIONSHIP: e.g., Mother, Father, Daughter, Son, Mother-in-law/Father-in-law, widow sister].
2. The particulars of the patient are correctly recorded in my official service book.

STATEMENT OF FACTS AND UNDERTAKINGS

1. Dependency Declaration: I solemnly declare that the patient, [PATIENT'S NAME], is wholly and solely dependent upon me for their livelihood, is residing with me at my address stated above, and that I have incurred the expenditure submitted for reimbursement.
2. Income Proof: I certify that my dependent(s) (including my parents, minor wards, or widow sister, if applicable) are neither employees anywhere nor pensioners. The total income from all sources of dependent patient i.e. mother, father, wards (with age detail: [LIST AGES]), widow sister, Father-in-Law, Mother-in-Law, etc.), does not exceed Rs. 3500/- (Rupees Three Thousand Five Hundred Only) per month (except for my Spouse).
3. Treatment Details: The patient got treatment for [DIAGNOSIS/AILMENT] at [NAME OF HOSPITAL/CLINIC] from [DATE OF ADMISSION] to [DATE OF DISCHARGE].
4. Employment Status: I certify that I am not an ad-hoc employee and am working on a regular basis with the organization.
5. Declaration of No Prior Claims: I assure that neither I nor the dependent has claimed or is claiming the reimbursement for this specific set of expenses from any other source, including any personal or government health insurance schemes.

Spouse's Employment Status (Strike out if not applicable)

6. If Spouse is Not Working: My wife/husband is not employed and is not entitled to any medical allowance or reimbursement from any source.
7. If Spouse is Working:
I certify that my wife/husband, [SPOUSE'S FULL NAME], is currently employed at [SPOUSE'S EMPLOYER].

I certify that my wife/husband is not getting any fixed medical allowance from any source.

I certify that my wife/husband has not claimed reimbursement for any of these specific medicines, tests, or treatment expenses from their employer or any other source.

Non-Empanelled Hospital Justification (If Applicable)

8. Non-Empanelled Justification: If the treatment was received at a non-empanelled hospital, I affirm that this was necessary due to [STATE JUSTIFICATION, e.g., A genuine medical emergency/lack of immediate availability of the required specialty at an empanelled hospital]. An emergency certificate is attached.

Agreement for Recovery

9. Agreement for Recovery: I agree and undertake that any excess payment made to me on account of this reimbursement claim can be recovered from my salary, pension, or any other outstanding dues, in the event that the above declarations are found to be false or incorrect upon verification.

Signature: _____ [FULL LEGAL NAME OF EMPLOYEE/AFFIANT]

CONCLUSION

I...do hereby solemnly swear or affirm and undertake under penalty of perjury that the following statements relating to the medical reimbursement claim are true and correct to the best of my knowledge, information, and belief?

Date: _____ Place: _____

Signature: _____ [FULL LEGAL NAME OF EMPLOYEE/AFFIANT]

[Employee ID] [Contact Phone Number]

NOTARY PUBLIC CERTIFICATION

(This section must be completed by a Notary Public)

Sworn to and subscribed before me this ___ day of _____, 20___, by [FULL LEGAL NAME OF EMPLOYEE/AFFIANT], who is personally known to me or who has produced _____ as identification.

NOTARY PUBLIC SIGNATURE: _____

Printed Name of Notary: _____

Notary Public in and for the State of [STATE]

(SEAL OF NOTARY)

Note: The above affidavit for reimbursement medical bill shall be attested from First Class Magistrate