



**DEPARTMENT OF GEOLOGY AND MINES
STAFF WELFARE SCHEME**

FORM C – BENEFIT CLAIM FORM

A. CLAIMANT DETAILS:

Name: *			
CID No.: *		Mobile No.: *	

B. TYPES OF CLAIM (tick the relevant one): *

i. Referral case of a member for medical treatment (go to C)	
ii. Demise of a Member/Beneficiaries (go to D)	
iii. Refund of SWS-DGM Contribution (go to E)	

C. REFERRAL CASE OF A MEMBER FOR MEDICAL TREATMENT OUTSIDE BHUTAN:

Illness (optional):			
Hospital referred to:	Name: *		
	Location: *		
A copy of referral letter from JDWNRH (tick if attached): *			

D. DEMISE OF A MEMBER/BENEFICIARIES:

Name: *			
CID No.: *		Relation:	
Date of death: *		Place of death: *	
A copy of Death Certificate either from Hospital or Gewog Administration (tick if attached):			

E. REFUND OF SWS-DGM CONTRIBUTION (if not made any claim and has been a member for minimum of 7 years)

Reason for claiming refund (tick the relevant one)	Transferred outside DGM:		Superannuation:	
	Resignation:		Termination:	
	Withdrawal from membership:			

A copy of Officer Order from HRD, MoEA in case of transfer, superannuation, resignation and termination from service (tick if attached):*	
Is your membership withdrawal accepted by Working Committee (applicable only withdrawing from SWS-DGM membership while still in service)?*	

**All field with an asterisk (*) are mandatory*

DECLARATION:
<i>The above information provided are correct to my knowledge and take full responsibility in case of any false claim and I accept the penalties as per the Article of SWS-DGM.</i>

Date:	(Claimant's Signature)
Place:	

FOR OFFICIAL USE	
Approving Working Committee:	
1. Chairman	2. Vice Chairman
3. Secretary	4. Treasurer(s)