

Form No. 1

GOVERNMENT OF ANDHRA PRADESH

DEPARTMENT / OFFICE.....

Dated.....

MEMORANDAM

Shri a Group

employee has been enrolled as a member of the Andhra Pradesh state Government

Employee Group Insurance Scheme, with effect from

His/Her monthly srbscripton of Rs

(Rupees

(shall be deducted from his salary / wage commencing from the month of

and he will be eligible to the benefits of the scheme appropriate to group

..... with effect from

.....

Head of Office

To,

*Shri

FORM No. 2

GOVERNMENT OF ANDHRA PRADHESH

DEPARTMENT / OFFICE

Dated

MEMORANDUM

*Shri has been promoted on a regular basis, from Group to Group with effect from His monthly subscription for the Andhra Pradesh State Employees Group Insurance Scheme, shall be raised from Rs to Rs from the month of and he will be eligible to the benefits of the scheme appropriate to Group with effect from

Head of Office

To

* Shri

* Name and designation of the employee.

FORM No. 3

To

The
.....

Sub:- Application for payment of accumulation under Andhra Pradesh State Employees Group Insurance Scheme.

Sir,

I have been a member of the Andhra Pradesh State Employees Group Insurance Scheme, since** I have retired from service after attaining the age of years / I have ceased to be in employment (eith the Andhra Pradesh Government / / Municipality with effect from I was holding the post of before retirement / / Municipality). I request that the amount due to me and the Andhra Pradesh State Employees' Group Insurance Scheme may be paid me.

Yours faithfully,

()

* Designation and address of the Head of office.

** Month and the year of becoming a member of the Scheme may be indict here.

FORM No. 4

GOVERNMENT OF ANDHRA PRADESH

DEPARTMENT / OFFICE

Dated.....

To

.....

.....

Sub:- Payment of the amount due under the Andhra Pradesh State Employees' Group Insurance Scheme.

Dear Sir / Madam,

I am directed to state that the late Shri has nominated you for payment of full / per cent of amounts due under the Andhra Pradesh State Employees' Group Insurance Scheme, 1984. You are therefore requested to submit an application in the enclosed Form No. 5 for arranging payment.

Yours faithfully,

()

* Name and address of the nominee.

FORM No. 5

To

* The
.....

Sub:- Application for payment of amount due to late Shri
..... under the Andhra Pradesh State Employees' Group
Insurance Scheme, 1984.

Sir,

With reference to your letter No dated

I hereby request that the full / per cent of amount due to late
Shri under the Andhra Pradesh State
Employees Group Insurance Scheme, may be paid to me.

Yours faithfully,

()

* Name and address of the Office where Form No. 4 is received.

FORM No. 6

NOMINATION FOR BENEFITS UNDER THE ANDHRA PRADESH STATE EMPLOYEES' GROUP INSURANCE SCHEME, 1984

When the Government employee has no family and wishes to nominate one person or more than one person.

I, having no family, hereby nominate the person / persons mentioned below and confer on him / them the right to receive to the extent specified below any amount that may be sanctioned by the Andhra Pradesh Government under the Andhra Pradesh State Employees' Group Insurance Scheme, 1984 in the event of my death while in service or which having become payable on my attaining the age of superannuation may remain unpaid at my death.

Names and addresses of nominee/nominees.	Relationship with Government employee	Age	* Share amount to be paid each	** Contingent on the happening of which the nomination shall become invalid	Name, address and relationship of the person, if any, to whom the right of the nominee shall pass in the event of his predeceasing the Government employee.
(1)	(2)	(3)	(4)	(5)	(6)
1.					
2.					
3.					

Dated this _____ day of _____ 198 at _____

Signature of two witnesses:

1.

2.

Signature of Government Employee

N.B:- The employee should draw line across the black space below his last entry to prevent the institution of any names after he has signed.

* This column should be filled in so as to cover the whole amount that may be payable under the Insurance Scheme.

** Where a Government employee who has no family makes a nomination, shall specify in this column that the nomination shall become invalid in the event of his subsequently acquiring a family.

FORM No. 7

NOMINATION FOR BENEFITS UNDER THE ANDHRA PRADESH STATE EMPLOYEES' GROUP INSURANCE SCHEME, 1984

When the Government employee has a family and wishes to nominate one member of more than one member thereof.

I hereby nominate the person(s) mentioned below, who is / are member(s) of my family, and confer in him / them the right to receive to the extent specified below any amount that may be sanctioned by the Andhra Pradesh Government under the Andhra Pradesh State Employees Group Insurance Scheme, 1984 in the event of my death while in service of which having become payable on my attaining the age of superannuation may remain unpaid my death.

Names and addresses of nominee/nominees	Relationship with Government employee	Age	* Share to be paid to each	Contingencies on the happening of which the nomination shall become invalid	Name, address and relationship of the person if any to whom the nominee shall pass in the event of his predeceasing the Government employee.
(1)	(2)	(3)	(4)	(5)	(6)
1.					
2.					
3.					

- 1.
- 2.
- 3.

Dated, this _____ day of _____ 198_____ at _____
Signature of two witnesses:

- 1.
- 2.

Signature of Government Employee

N.B: The employee should draw line across the blank space below his last entry to prevent insertion of any names after he has signed.

* This column should be filled in so as to cover the whole amount that may be payable under the Insurance Scheme.

FORM No.8
ANDHRA PRADESH STATE EMPLOYEES' GROUP
INSURANCE SCHEME **GROUP**
REGISTER OF MEMBERS

SECTION I: Particulars of employees subscribing to the Insurance Fund only.

S.No.	Name	Desig- nation	Date of Birth	Date of appoint	Date of comm- ecment	Date of promot- ion to hi- gher Gro- up/ Date of transfer to other departm- ent(s)	Date of death	Remarks
1	2	3	4	5	6	7	8	9

SECTION –II: Particulars of employees subscribing to both Insurance Fund and Savings Fund.

S.No.	Name	Desig- nation	Date of birth	Date of appoint- ment	Date of comm.- ncement of subs- cription	Date of promo- tion to higher Group/ Date of transfer to other Depart- ment(s)	Date of death	Remarks
1	2	3	4	5	6	7	8	9