श्री अरविन्द महाविद्यालय (सांध्य)
(दिल्ली विश्वविद्यालय)
मालवीय नगर, नई दिल्ली-110017
दूरभाष: 011-41751306
ई-मेल: principal@aurobindoe.du.ac.in
वेबसाइट: www.aurobindoe.du.ac.in

SRI AUROBINDO COLLEGE (EVENING)
(UNIVERSITY OF DELHI)
MALVIYA NAGAR, NEW DELHI-110017
Phone: 011-41751306
Email: principal@aurobindoe.du.ac.in
Website: www.aurobindoe.du.ac.in

Ref. No. SAC(E)/2026-27/232

Date: 18.08.2026

NOTICE REMINDER

This is with reference to the office notice bearing Ref. No. SAC(E)/2026-27/224 dated 07.08.2026 regarding **Group Insurance Scheme with LIC of India**, introduced to provide social security benefits to the dependents of university employee. The last date for submission of the Consent Form was **14.08.2026**, which is hereby **extended up to 31.08.2026**.

In this connection, all Teaching and Non-Teaching staff members who wish to avail this facility are required to fill in the **Consent Form by 31.08.2026** for joining the Group Insurance Scheme (copy enclosed) and submit the duly filled form to the **Section Officer (Accounts)** at the earliest, so that the scheme may be implemented in a timely manner.

(Prof. Vipin Kumar Aggarwal)
Principal (OSD)

Copy to:

(i) Administrative Officer (Accounts)
(ii) Section Officer (Accounts)
(iii) All teaching staff
(iv) All non-teaching staff
(v) College Website

SRI AUROBINDO COLLEGE (EVENING)

(UNIVERSITY OF DELHI)

MALVIYA NAGAR, NEW DELHI-110017

Consent Form to join Group Insurance Scheme

Employee Code	Name of Employee (in Capital)	Date of Birth (dd/mm/yyyy)	Date of Appointment (dd/mm/yyyy)	Monthly Salary (Basic plus DA only)	Aadhar Card No.	Email Id	Mobile No.	Department where working	Father' s Name / Spouse' s Name	Whether appointment Regular / Contractual	Name of the Nominee – Specify whether Wife/Husband/Son/Daughter/Father/Mother/Other dependent	Date of Birth of Nominee	Aadhar Card of Nominee

I hereby give my consent for join "**Group Insurance Scheme**" by contributing a sum of **Rs. 500 + GST** amount for taking **Group Insurance Scheme** for a sum assured of **Rs. 20 Lakh** only in case of death. Relief to my eligible family Member/Nominee. **I am fully aware that there is no survival benefit.**

I hereby give my consent to Deduct the Contribution amount from my Salary per month for depositing with the LIC of India.

I confirm that I have read and fully understood the "**Group Insurance Scheme**" benefits, terms and condition.

The rates are tentative as Provided by LIC of India may change from time to time as per LIC Policy..

Date : _____

Full Signature of Employee