EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM- 10
CONFIDENTIAL

ABSTENTION VERIFICATION IN RESPECT OF SICKNESS BENEFIT/ TEMPORARY DISABLEMENT BENEFIT / MATERNITY BENEFIT
(Regulation 52-A)

From :

The Manager

___________________ Branch Office,

E.S.I. Corporation,

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To :

M/s ______________________________

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Subject: Verification of abstention from work in respect of Shri/Smt./Kum _______________
Ins.No. ________________________________ Department ________________________

Dear Sir(s)

The above named employee of your factory has submitted a certificate of incapacity for the period from _______________________ to ________________________ and has declared that he/ she has not worked on any day during the above period.

He/ she has further declared that he/ she has not received wages as defined under section 2(22) of ESI Act, 1948 for any leave/holiday/weekly off/ lay off and strike in respect of any day during the above period and that he/she was not on strike on any day during the above period.

I shall be grateful if you confirm the exact position, in this regard, on the form, appended within 10 days of the receipt of this form.

Yours faithfully,

(Manager)

________________ Branch Office

EMPLOYEES' STATE INSURANCE CORPORATION

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REPLY TO BE FURNISHED BY THE EMPLOYER
IN RESPECT OF FORM NO. 10

Name of the Insured Person/ Insured Woman ____

Insurance No. ___________________________

Returned with the remarks that the employee in question has not worked on any day during the period from ___________________ to ______________________ or* that he/she has worked on _____________________ during the period from ___________________ to _____________________

It is further confirmed that –

(a) He / she remained on leave with wages for the period from _______________ to ____________

(b) He/ she remained on holidays with wages from ______________________ to ______________

(c) He / she was on weekly off with wages for ________________________to _________________

(d) He / she was on lay-off with wages from _______________________to ___________________

(e) He / she was on strike from ______________________________ to ________________________

2. In case, the IP/IW is paid any wages for any of the days falling during the above mentioned period subsequently, the same will be notified to you in due course.

3. The day proceeding the first day of absence was*/was not a holiday for the Insured Person/Insured Women.

Date: ______________ **Signature** ______________________________

Name in block letter & Designation __________________________

Code No. _______________________________

* Strike out if not applicable