EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM – 10
CONFIDENTIAL

ABSTENTION VERIFICATION IN RESPECT OF SICKNESS BENEFIT/ TEMPORARY DISABLEMENT BENEFIT/ MATERNITY BENEFIT

EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 52-A)

From:

The Manager
___________Branch Office,
E.S.I. Corporation,

To:

M/s. ________________________________

____

Subject:- Verification of abstention from work in respect of Sh./Smt./Km.________________
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 _______________________________

(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 Woman.

Date:_________________ **Signature**____________________________________

Name in block letter & Designation__________________________

Code No. ___________________________________

* Strike out if not applicable