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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,

_____

To :

M/s _____

_____

_____

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

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

Name of the Insured Person/ Insured Woman P Avinash Kumar
Insurance No. 70XXXX123456

Returned with the remarks that the employee in question has not worked on any day during the period from 01-04-2017 to 15-04-2017 or* that he/she has worked on ----- during the period from -------- to ------

(If employee works on any day in between 1- 15-04-2017 then mention those details in above blanks, other wise leave blank)

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: 16-04-2017

Signature Signature of employer
Name in block letter & Designation A Divakar & HR Executive
Code No. 60530258XXXX10123

* Strike out if not applicable