FORM 13

EMPLOYEES' STATE INSURANCE CORPORATION

SICKNESS OR TEMPORARY DISABLEMENT OR MATERNITY BENEFIT FOR SICKNESS

[Regulation 63 and 89B]

CLAIM FOR BENEFIT

I, ... son/wife/daughter of .....Insurance No..... declare that, because of sickness / temporary disablement, I have not been at work since the date mentioned in the first / last certificate sent to you.

[1][I have not been in receipt of wages on account of leave, holidays. I was not on strike during the period of certified abstention for which benefit is claimed.]

I claim benefit accordingly. I desire payment in cash at Branch office / by money order.

Date .....

Signature or thumb impression

Branch Office .....

Present address (if changed) .....

Important :

(1) Any person who makes a false statement or representation for the purpose of obtaining benefit whether for himself or for some other person renders himself liable to prosecution.

(2) This form should be completed and sent without delay to the appropriate Branch office.

(3) The insured person should obtain a final certificate before resuming work.