

ESIC

BRANCH OFFICE MANUAL

FOURTH EDITION

(UPDATED TILL JULY, 2010)

FOR OFFICIAL USE ONLY



PUBLISHED BY
DIRECTOR GENERAL

कर्मचारी राज्य बीमा निगम

EMPLOYEES' STATE INSURANCE CORPORATION

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PREFACE TO THE FOURTH EDITION

Employees' State Insurance Corporation is implementing country's Social Security Scheme. It has now more than 4 crore workers and their family members under its umbrella. In order to render the best possible services to its beneficiaries, the Corporation believes in creating an atmosphere of co-operation and mutual trust amongst the stakeholders i.e. the Employers, the Beneficiaries and the ESI Corporation.

The Branch Office Manual, a corporate publication of the ESIC, is an essential reference and guide book for effective delivery of social security services, to the vast clientele of ESI beneficiaries. The fact, that the Corporation on average, makes 30 lakh cash benefit payments annually, through its broad base network of over 611 Branch Offices and 197 Pay Offices, underlines the importance of publication, for day to day operations.

The last edition of the Branch Office manual was brought out in 2000, almost a decade back, and hence the need for a revised edition. This edition of the Manual, has been updated carefully and incorporates all important amendments made in Act, Rules and Regulations relating to provisions on Benefits. A new Chapter has been added in the revised edition- Chapter XIV on Finance & Accounts of Branch Office. Further, Chapter IV on Temporary Disablement Law has been bifurcated and provisions relating to Occupational Diseases have been incorporated in Chapter IV-A. Similarly, provisions relating to Unemployment Allowance under RGSKY have been incorporated in chapter – XII and Super Speciality Treatment in Chapter XIII. These additions will make understanding of issues on important subjects easier for all concerned.

I am hopeful, that, this updated edition of the Manual shall prove very useful at the operative level in ESIC Establishments and thereby, help in increasing the overall efficiency towards speedy and smooth flow of benefits to the insured population.

Here, I find it opportune, to express my deep gratitude and thanks to Officers & Staff of the Benefit Division and Shri H.K.Ahuja (Retd. Jt.I.C.) whose relentless efforts have enabled the ESIC Headquarters to come out with this revised edition.

Each section of the book has been compiled with utmost care. Constructive suggestions for improvement of the book will be highly appreciated.



(B.K.SAHU)

INSURANCE COMMISSIONER, ESIC

New Delhi

Dated 02.03.2010

FOREWORD TO FOURTH EDITION

From humble beginning in 1952 at Delhi and Kanpur ESI Corporation has acquired a Pan-India presence and it now serves its beneficiaries in all corners of the country. Today, we provide insurance and health care to more than 40 million population. This not only makes us one of the largest health service providers in the world but also a unique one as we are insurer as well as service provider.

As a result of improved educational and living standards, the expectations of our beneficiaries have also risen. To meet the aspirations of our stakeholders, a large number of new initiatives have been taken by the Corporation including up gradation of our existing Hospitals, Dispensaries, Branch Offices, construction of new corporate standard Hospitals, IT Roll Out, payment of PDB/DB through ECS and streamlining procedure involving delivery of medical & cash benefits for ultimate goal of '**Kahin bhi, Kabhi bhi**' services.

In order to provide quality service with speed it is essential that every stake holder should be fully conversant with the latest rules and regulations of the ESI Scheme. In this backdrop, it is gratifying to dedicate this revised, knowledge-based and updated version of the Branch Office Manual to ESIC establishments across the country. I am sure that availability of this exhaustive compilation of laws and procedures, concerning delivery of benefits and other related areas of activity, shall further enhance the efficacy of our field offices. I look forward to its extensive use by our officers and staff.



(Dr. C.S.KEDAR, I.A.S.)
DIRECTOR GENERAL, ESIC

New Delhi
Dated 02.03.2010

**EMPLOYEES' STATE INSURANCE CORPORATION
BRANCH OFFICE MANUAL (Fourth Edition)**

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ABBREVIATIONS USED IN THIS MANUAL

A – Day	Appointed Day
A.E. or AE	Alternative evidence
A.L.C. or ALC	Artificial Limb Centre
A.M.O. or AMO	Administrative Medical Officer
B.O. or BO	Branch Office
B.M. or BM	Branch Manager
B.P. or BP	Benefit Period
C.P. or CP	Contribution Period
D.B. or DB	Dependants' benefit
D.I.C. or DIC	Duplicate identity card
DF	Declaration form
D.O. or DO	Divisional Office
ESB	Extended sickness benefit
ESIC	Employees' State Insurance Corporation
HC	Head Clerk
I.M.O. or IMO	Insurance Medical Officer
I.M.P. or imp	Insurance Medical Practitioner
I.P. or IP	Insured Person
I.W. or IW	Insured Woman
L.T.I. or LTI	Left Thumb Impression
M.A.T. or MAT	Medical Appeal Tribunal
M.C. or MC	Medical Commissioner
M.R. or MR	Medical Referee
M.C.R. or MCR	Medical Record Card
M.R.E. or MRE	Medical Record envelop
O.D. or OD	Occupational disease
P.D.B. or PDB	Permanent Disablement Benefit
P.E.P.A. or PEPA	Per employee per annum
P.I.C. or PIC	Permanent Identity Card
R.C. or RC	Return of contributions
R.D. or RD	Regional Director
R.D.F. or RDF	Return of declaration forms
R.D.M.C. or RDMC	Regional Dy. Medical Commissioner
R.O. or RO	Regional Office
R.T.I. or RTI	Right Thumb Impression
S.B. or SB	Sickness Benefit
S.M.C. or SMC	State Medical Commissioner
S.R.O. or SRO	Sub Regional Office
S.S.M.C. or SSMC	Sr. State Medical Commissioner
T.I. or TI	Thumb impression
T.I.C. or TIC	Temporary identification certificate
U.D.C. or UDC	Upper Division Clerk
V.R.C. or VRC	Vocational Rehabilitation Centre
V.R.S. or VRS	Vocational Rehabilitation Scheme

CHAPTER I

REGISTRATION – (a) LAW & PROCEDURE - GENERAL

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CHAPTER I

REGISTRATION – (a) LAW & PROCEDURE - GENERAL

What is registration?

1.1 Registration is the process by which every employer/factory/establishment and its every employee employed for wages, is identified for the purpose of the Scheme, and their individual records are set up for them.

The first step in the process is the obtaining of particulars about each coverable factory/shop/establishment, and its identification by allotment of a number i.e. Code No. by the Regional Office so as to facilitate keep track of contributions payable/paid and the connected obligations of the employers. Subsequent step is the registration of employees of covered factories by the Regional Office/Branch Office (where the work of registration of employees is decentralised), and identifying them by allotment of a number i.e., insurance number, and setting up of necessary records for recording the benefits for which the insured employee may be entitled under the Scheme. Individual record of each employer/employee is by nature subject to necessary change as and when required and will also facilitate monitoring of compliance by the employer as well as flow of benefits to eligible IPs.

Registration of employers

1.2 Section 2A of the ESI Act states as under:-

2A. Registration of factories and establishments : Every factory or establishment to which this Act applies shall be registered within such time and in such manner as may be specified in the regulations made in this behalf.

1.3. As a follow-up of this provision in the Act, Regulation 10B was inserted in the ESI (General) Regulations, 1950. This regulation states as under: -

10B. Registration of factories or establishments :

- (a) The employer in respect of a factory or establishment to which the Act applies for the first time and to which an Employer's Code No. is not yet allotted, and the employer in respect of a factory or an establishment to which the Act previously applied but has ceased to apply for the time being, shall furnish to the appropriate R. O. not later than 15 days after the Act becomes applicable, as the case may be, to the factory or establishment, a declaration of registration in writing in form 01 (hereinafter referred to as employers' registration form).
- (b) The employer shall be responsible for the correctness of all the particulars and information required to be furnished on the employer's registration form.
- (c) The appropriate Regional Office may direct the employer who fails to comply with the requirements of paragraph (a) of this regulation within the time stated therein, to furnish to that office employer's registration form duly completed within such further time as may be specified and such employer shall, thereupon, comply with the instructions issued by that office in this behalf.
- (cc) The employer in respect of a factory or establishment to which a code number has been issued by the Corporation based on the information collected or decision taken regarding applicability of the Act to such factory or establishment, shall, within fifteen days of receipt of information of allotment of code number furnish a declaration in form 01 (Added w.e.f.1.1.05)

- (d) Upon receipt of the completed employer's registration form, the appropriate R. O. shall, if satisfied that the factory or the establishment is one to which the Act applies, allot to it an employer's code number (unless the factory or the establishment has already been allotted an employer's code number) and shall inform the employer of that number.
- (e) The employer shall enter the employer's code number on all documents prepared or completed by him in connection with the Act, the rules and these regulations and in all correspondence with the appropriate office.

Submission of annual information by factories / establishments.-

10C. The employer in respect of a factory or establishment to which this Act applies and to whom a code number has already been allotted, shall furnish to the appropriate Regional Office or Sub Regional Office or Divisional Office by 31st of January every year, a return in form 01A. The employer shall be responsible for correctness of all particulars and information furnished in form 01A (Added w.e.f.1.1.05)

Coverage of employees of new factory/estt. – BM's role

1.4. Regional Office supervises and controls the registration of factories and establishments under the Act and the Branch Office normally comes into the picture only after a code number has been allotted to a factory/establishment by the Regional Office. The R. O. invariably sends a copy of the code number intimation to the Branch Manager. However, Branch Office can play an important role on certain aspects of registration of factories /establishments as described below: -

- i. The Branch Office will maintain a list of covered factories/establishments allotted to it and shall keep this list absolutely up-to-date by adding those brought under coverage from time to time. Suitable remarks should be added against factories/establishments going out of coverage on the authority of the Regional Office letter number and date which should invariably be quoted in the remarks column and attested by the Manager. The Branch Office on its own authority cannot treat a factory/establishment covered or otherwise.
- ii. An employer, on allotment of code number, would approach the Branch Office and he should be given full training and information on forms to be filled in, records to be set up and returns to be submitted. At this juncture, the Corporation expects every Branch Manager and his staff to play an important role in providing both guidance and information and thus help popularise the Scheme.
- iii. Sometimes a factory/establishment is covered with retrospective effect, and in such cases employer is likely to give the date of employment of coverable employees wrongly in the declaration forms, e.g., date of filling of forms or date on which he receives the code number etc. This mistake can create serious complications in matters of eligibility decision of benefits to insured persons and even denial of benefits to some persons employed from earlier dates. As the employer is liable for payment of contribution for past periods also, the Branch Manager should advise the employer to indicate the 'date of entry in insurable employment' or the date of coverage of factory or actual date of employment, whichever is later. The employer should also be advised to calculate and pay the contribution individually in respect of all the employees who were in employment on or after the date of coverage of the factory.
- iv. A factory/establishment applies to the R. O. for registration under the Act but awaits receipt of a code number. Meanwhile, a serious accident occurs in the factory and the employer brings it to the notice of the Branch Manager and approaches him for arranging medical care of the injured person on the ground that his factory/establishment is covered under the Act, that he has applied for a code number which is awaited from the Regional Office. Normally, since the Regional Office has to satisfy itself about coverage of a factory before allotting it a

code number, registration of employees of the factory/establishment in the absence of a code number is not advisable. At the same time, under the law, the Corporation is responsible for payment of benefits to employees of a covered factory/establishment. In such cases, the Branch Manager should pay a quick visit to the employer's premises and check attendance/wage records and satisfy himself --

- a) that the factory/establishment is coverable from a date *earlier than the date* of accident,
- b) that form 01 has also been sent earlier than the reported date of accident, and
- c) that the injured person was working as an 'employee' at the time of the injury.

Once satisfied, he should ask the employer to submit urgently ESIC-86 of the injured person. The employer would mention "Applied for" in the code number column. On its receipt, the BM will enclose with it an urgent letter addressed to IMO in charge of the dispensary opted by the IP, requesting for medical attendance and treatment.

BM will then at once send his survey report with a DO letter to R. D., requesting for coverage decision, intimating the full facts of the accident necessitating survey.

- v. A factory/establishment was allotted a code number earlier, it then being covered under the Act but later went out of coverage and had ceased submitting declaration forms. However, the Branch Office suddenly finds a bunch of declaration forms received from such a factory/establishment. Since the old code number allotted to this factory/establishment would be quoted by the employer, the Branch Office has to be extra careful in accepting the declaration forms. In such cases, the Branch Office should satisfy itself from the records of the Branch Office that the factory/establishment has again been treated as covered under the Act by the Regional Office. A letter should be addressed to the Insurance branch at R. O. to confirm immediately that the factory/establishment has been treated as covered again, if no record is available in the B. O. about its re-coverage.

Registration of employees

1.5 Relevant Regulations contained in the ESI (General) Regulations, 1950 as amended, which regulate the registration of insured persons and their families, are reproduced below for ready reference.

REG. 11. Declaration by persons in employment on appointed day.— The employer in respect of a factory or an establishment shall require every employee in such factory or establishment to furnish and such employee shall on demand furnish to him either before or on the appointed day correct particulars alongwith his/her photograph and that of his/her family required for the purpose of form-1 (hereinafter referred to as the declaration form). Such employer shall enter the particulars in the declaration form including the temporary identification certificate, and obtain the signature or the thumb impression of such employee and also complete the form as indicated thereon.

REG.12. Declaration by persons engaged after the appointed day .— (1) The employer in respect of a factory or an establishment shall, before taking any person into employment in such factory or establishment after the appointed day, require such person (unless he can produce an identity card or other document in lieu thereof issued to him under these regulations) to furnish and such person shall on demand furnish to him correct particulars alongwith his/her photograph and that of his/her family required for the declaration form, including the temporary identification certificate, and obtain the signature or the thumb impression of such person and also complete the form as indicated thereon. (2) Where an identity card is produced under sub-regulation (1), the employer shall make relevant entries thereon.

REG. 14. Declaration Form to be sent to appropriate office.— The employer shall send to the appropriate office by registered post or messenger, all declaration forms without detaching the temporary

identification certificate prepared under these regulations together with a return in duplicate in form 3 within 10 days of the date on which the particulars for declaration forms were furnished.

REG. 15. Allotment of Insurance Number.— On receipt of the return required under Regulation 14, the appropriate office shall promptly allot an insurance number to each person in respect of whom the declaration form has been received unless it finds that the person had already been allotted an insurance number. The temporary identification certificate with insurance number marked thereon shall be detached and returned to the employer alongwith one copy of form 3. The employer shall deliver the temporary identification certificate to the employee to whom it relates after obtaining his signature or thumb impression thereon except in the case of an employee to whom a certificate of employment has been issued under Regulation 17A. The insurance number allotted by the appropriate office to an employee and indicated in the copy of Form 3 returned to the employer, shall be entered by the employer in the register of employees-form 7 (renumbered as from 6 w.e.f.. 1.1.2005).

REG. 15A. Registration of families.— On the issue of a notification under Regulation 95-A specifying the date from which the family of an insured person shall also be entitled to medical benefit under the Act, every insured person who has not furnished the particulars of his family at the time of his registration under the Act, shall furnish to the employer correct particulars alongwith their photograph in respect of his family in form 1-A. The employer shall enter the particulars in the form and obtain the signature or the thumb impression of such person and complete the form as indicated thereon and send it to the appropriate office within 10 days of the date on which the particulars were furnished.

REG. 15B. Changes in family.— An insured person shall intimate all changes in membership of the family as defined under the Act, to the employer within 15 days of such change having occurred and the employer shall enter such particulars in form 1-B (renumbered as form 2 w.e.f.. 1.1.2005) and shall forward it to the appropriate office within 10 days of the date on which the particulars of changes were furnished.

REG. 16. Corporation to receive assistance from employers.— An employer shall render all necessary assistance which the Corporation may require in connection with the registration of his factory or establishment and the registration of his employees and specially for photographing such employees and affixing the photographs to the identity cards.

REG. 17. Identity Card.— The appropriate office shall arrange to have an identity card prepared in form 4 for each person alongwith the photograph in respect of whom an insurance number is allotted and shall include in such card the particulars and photograph of his/her family in respect of the family entitled to medical benefit under Regulation 95-A and send all such identity cards to the employer. Such employer shall if and when the employee has been in his service for 3 months, obtain the signature or thumb impression of the employee on the identity card and shall after making relevant entries thereon deliver the identity card to him. The employer shall obtain a receipt from the employee for the identity card. The identity card in respect of an employee who has left employment before 3 months shall not be given to him, but shall be returned to appropriate office as soon as possible. The identity card shall not be transferable. Note: If it is decided to provide a separate identity card for his family, it will be issued in form 4A (See Reg. 95A).

REG. 17A. Issue of a certificate of employment.— If an insured person happens to need medical care before the temporary identification certificate is issued to him, the employer shall issue a certificate of employment in such form as may be specified by the Director General to such person on demand. Such certificate shall also be issued on demand, if an insured person loses his temporary identification certificate before the receipt of identity card

REG. 17B. Issue of permanent acceptance card.— In areas where the Director General considers it appropriate the appropriate office shall also supply the permanent acceptance card for each employee in such form as the Director General may specify alongwith the identity card and this shall also be delivered to the employee. Permanent acceptance card for the employee who has left employment before 3 months shall not be given to him but returned to the appropriate office alongwith the identity card as soon as possible.

1.6. Mass registration is carried out in an area where the Scheme is implemented for the first time to factories under Section 1(3) of the Act or in areas where it is extended subsequently to certain establishments under Section 1(5) of the Act. It is thus a one-time process. After the Scheme has been implemented, or has been extended to establishments, new entrants continue to join insurable employment in covered factories/establishments and their registration is necessary. This second type of registration is thus an on-going process in every implemented area and the paragraphs that follow describe this type of registration. Mass registration has features common to subsequent registration. Therefore, the additional or special steps required under it have been described in paragraphs 1.52 to 1.67 of this Chapter.

Office of registration

1.7. Unless otherwise specified for any area, registration of employees is carried out at the Branch Office. The Regional Office supplies to each Branch Office a list of factories/establishments attached to it with their full addresses and code numbers etc. alongwith the block of insurance numbers separately for male and female employees for allotment of insurance numbers and the Branch Office has to conduct registration of employees of these factories/establishments by allotting Ins. Nos. out of the specified block of insurance numbers only. If in the same area, there are more Branch Offices than one, each will be allotted a separate block of insurance numbers and each will carry out registration of employees of only those factories/establishments which are attached to it.

Registration forms etc.

1.8. Every Branch Office should periodically indent from the Regional Office and maintain at all times an adequate stock of the following blank forms for supply to the factories/establishments attached to it according to their requirements: -

REGULATION FORMS

1. Declaration form (Form-1)
2. Return of declaration form (Form-3)
3. Continuation sheets of the return of declaration forms.
4. Return of contributions (Form-6 - (renumbered as form 5 w.e.f.. 1.1.2005)
5. Continuation sheets of return of contributions

NON-REGULATION FORMS

ESIC-37

ESIC-86

ESIC-105

Bank Challan forms

1.9. Branch Office should also maintain adequate stocks of forms meant for its own use under this procedure. This includes stocks of identity cards, family identity cards (form 4A) medical record envelopes, index cards, index sheets, ledger sheets, ledger binders. In areas where medical care is provided through panel system, the Branch Office should also have a stock of blank temporary acceptance cards and permanent acceptance cards.

1.10. Account of the receipt and issue of blank forms shall be maintained in the stock register of printed forms prescribed by the Headquarters (specimen at Annexure I). Forms sent to the employers should be accompanied by a challan in form ESIC-120 in duplicate (Annexure II). One copy duly receipted by the employer should on return be placed in chronological order in the challans file. Forms issued for consumption should be entered in the stock register. Only the monthly totals of receipts and issues should be carried out. Printed/cyclostyled copies of form ESIC-120 may also be requisitioned from the Regional Office.

Rubber stamps for use by employer

1.11. Employers should be advised to get the following rubber stamps prepared to cut down repetitive writing on the declaration forms:

- a) Employer's Code No.
- b) Name and designation of the officer countersigning the declaration forms.
- c) Name, address and Code No. of the employer.
- d) **FEMALE.**

Declaration form of a new entrant

1.12. As provided in Regulation 12 quoted under paragraph 1.5 above, an employer has to collect particulars of each new entrant alongwith his/her photograph and that of his/her family and enter them in a declaration form before taking him/her into employment. Further, as provided in Reg. 14, this declaration form complete in all respects alongwith a return of declaration form in duplicate has to be sent by the employer to the appropriate Branch Office within 10 days. Declaration forms of female employees will be stamped 'FEMALE' and submitted alongwith a separate return of declaration forms. Two copies of post card size photograph of the IP with his /her family as the case may be, should be attached with the declaration form of the concerned employee.

1.12A. Declaration forms received by post without photographs in contravention of Regulation 12 should not be returned but the employer should be requested to submit the photographs. Declaration forms without photographs received by hand should be returned on the spot with the advice to resubmit them along with family photographs of new entrants.

Late submission of declaration forms

1.13. Timely submission of declaration forms by every employer should be kept under watch. While minor delays may be excused with a verbal advice, persistent delays and for longer periods should not be ignored. Whenever an employer submits some or all declaration forms later than the time limit laid down in Reg. 14 by more than 7 days after the due date of submission, he should be informed through the issue of a standard letter No. 1 (Specimen at Annexure III) and his future performance be watched. For a second and similar delay by the employer, the same letter may be issued as in the case of the first delay. When the first 2 letters in Annexure III have been ignored and a third delay takes place, letter No. 2 (Annexure IV) should be issued under certificate of posting. If the employer still persists in sending the declaration forms late, letter No. 3 (Annexure V) should be issued under certificate of posting.

1.13A. To keep a watch on employers who frequently delay submission of declaration forms, the Branch Office may open a register having a few columns suggested below: -

1. Employer's name and code number.
2. Insurance numbers of declaration forms received late *.

3. Serial number and date of letter to employer **.
4. Instance of delay, i.e. 1st, 2nd, 3rd etc.
5. Date of reference to Regional Office.
6. Initials of Branch Manager.

* i. e. declaration forms received 17 or more days late after date of entry by I. Ps may be entered in this column.

** i. e. the Serial No. 1/2/3 of letter issued as in this Manual.

1.14. Where the employer continues to delay submission of declaration forms even after issue of 3 letters mentioned above have been issued, the Manager should recommend prosecution action to the Regional Office. In his letter to Regional Office he will quote instances of late submission with full particulars of persons, their dates of appointment and the date of despatch by employer and receipt in Branch Office, of all the declaration forms received during the preceding 6 months prior to the date of issue of his recommendation to the Regional Office.

1.15. The Regional Office will promptly issue letter No. 4 (show cause notice) *vide* Annexure VI asking the employer as to why prosecution action should not be taken against him for persistent delays in the submission of declaration forms. If there is no satisfactory reply and no assurance about timely submission of declaration forms in future is forthcoming, prosecution action should be taken. Prosecution action should be taken only in cases of general persistent delays.

1.16. Apropos delay in submission of declaration forms, in cases where an accident report is received soon after an insured person joins insurable employment, the Manager should personally investigate the case irrespective of the nature of injury with a view to ensure that the employer has not been defaulting in covering all insurable employees of his factory/establishment and that he has not filled in the declarations form of the person only after he met with the accident.

Filling up of declaration forms

1.17. The following points should be borne in mind by the employer's clerk when a declaration form is filled:

- (i) Each declaration form should be written legibly. No column should be left blank.
- (ii) The insurance number box should be left blank. This is to be filled in by the Regional Office/Branch Office.
- (iii) Name of employee should be written in block letters e. g. TARA CHAND.
- (iv) Name should be written in the usual order in which it is spoken i. e., the first name or the Christian name of the employee and then the second name, if any, for instance the name of the father where it is used, and finally the surname, if any, e. g., TARA CHAND MATHUR.
- (v) Prefixes like Mr. Shri, Lala, Pandit, Sardar, Shrimati, etc. should not be written either with the employee's own name or with that of his/her father/husband.
- (vi) If father's name is not available, mother's name may be entered with a remark to that effect in the relevant column.

- (vii) In case of married female employees, only the husband's name should be given. In case she does not give her husband's name, it may be ascertained from the employer's record and then read out for her confirmation.
- (viii) Two copies of postcard size photograph of the IP with his/her family, as the case may be, should be obtained.
- (ix) Where the exact year of birth cannot be recollected by the employee, the age as stated by him should be recorded. If the employee cannot give his age his apparent age should be entered. The year of birth then be worked out and entered.
- (x) Every effort should be made to obtain as complete an address as possible. If an employee is unable to give his place of residence, having none, he should give some address by which he can be located. If he does not remember his house number, he should be asked to bring it next day.
- (xi) No effort should be spared to obtain the nominee's name. It may be impressed upon the employee that if the name of a nominee is not given, any amount that may be due to him in the event of his death, cannot be paid to anyone without the production of a succession certificate. Nomination of more than one person should not be encouraged but if a nomination is made favouring more than one person, the employee should be asked to indicate the share of each nominee.
- (xii) Where the employee has the option to choose his dispensary he should be advised to choose the one nearest to his residence. If panel system is in operation in the area, the column should be left blank, In such an area, the insured person will be given a permanent medical acceptance card alongwith the identity card on which he will choose the doctor and take it to him for necessary action.
- (xiii) For particulars of family, the part of the temporary identification certificate should be folded backwards at the black dividing line provided. A carbon paper may then be inserted between the folds and family particulars be recorded with the help of a ballpoint pen. In this way, the family particulars can be recorded at one stroke both in the body of the declaration form and in the temporary identification certificate. Due care should also be taken to enter the names and particulars of those family members only who fall within the definition of family of the IP. "Family" as defined under Section 2(11) of the Act means the following: -
 - (i) Spouse, i. e., wife of IP or husband of an insured woman (whether dependent or not);
 - (ii) a minor legitimate or adopted child, dependent upon the insured person;
 - (iii) a child who is wholly dependent on the earnings of the insured person and who is-
 - (a) receiving education, till he or she attains the age of 21 years,
 - (b) an unmarried daughter,
 - (iv) a child who is infirm by reason of any physical or mental abnormality or injury and is wholly dependent on the earnings of the insured person, so long as the infirmity continues;
 - (v) Dependent parents. The Standing Committee / ESI Corporation at their meetings held on 17.12.2004 decided that only those parents whose monthly income from all sources is less than Rs 1500/- and who normally reside with the IP, will be entitled to medical care under the ESI scheme. A declaration to this effect shall be taken from the IP at the time of filling in the declaration form.

The above definition of “family” is also provided in every declaration form (Form 1) and it includes the following:

- (i) A wholly dependent son, who is receiving education, upto age 21.
- (ii) Subject to being wholly dependent:
 - (a) an unmarried daughter irrespective of her age; and
 - (b) an infirm son or daughter irrespective of his or her age until the infirmity lasts or infirm daughter gets married, whichever is earlier.

The above definition excludes the following: -

- (a) Children who have attained majority.
 - (b) Married daughter even if minor.
 - (c) Minor brothers and sisters even if dependent.
 - (d) Parents who are not dependent.
 - (e) Grand children, even if dependent.
 - (f) Mother-in-law of an insured woman even if widowed and dependent and her father-in-law even if dependent.
- (xiv) Name of Branch Office will be that to which the factory/establishment is attached.
 - (xv) The signature or thumb impression of the employee should invariably be obtained on his declaration form in the space provided for the purpose.
 - (xvi) The employer’s clerk filling in the declaration form should sign at the place provided for the purpose. This form should then be countersigned by an executive official of the factory/establishment, e. g. the manager, the labour officer or any other officer as may be authorised by the employer.
 - (xvii) The full name, address and code number of the factory/establishment should invariably be given on page 2 of the declaration form in the space provided for that purpose.
 - (xviii) The temporary identification certificate at the foot of the declaration form is also to be completed by the employer. This is not to be detached while sending the declaration form to the Branch Office which will later return this to the employer after entering the insurance number thereon.
 - (xix) The identification marks of the insured person as well as of his family members will be recorded by the Insurance Medical Officer/Insurance Medical Practitioner on the identity card of the insured person at the time of his/their first visit to the doctor; so also in the case of duplicate identity card when he visits the Insurance Medical Officer/Insurance Medical Practitioner after the receipt of the duplicate identity card. In this connection Para 1.89 of this chapter may be referred to for compliance by Branch Office.

Return of declaration forms

1.18. The filled up declaration forms are to be forwarded by the employer to the Branch Office to which he is attached alongwith the return of such declaration forms (Form-3) prepared in duplicate. The names of the employees whose declaration forms are sent to the Branch Office should be serially listed on the return of declaration forms. Columns 1 to 4 have to be filled in by the employer. Column 3 of the Return should be carefully filled in. Where there is no distinguishing number, such as token No., the department, shift, loom etc. to which the employee belongs or in which he is working may be given. The declaration forms listed on the Return should be tagged with it.

1.19. Where any two or more employees have the same name, no effort should be spared to keep them easily distinguishable from one another. The distinguishing sign or symbol should be made part of the name both in the declaration form and the return of declaration forms and the same should also be entered by the employer in his own records so as to avoid confusion at all stages in payment of contributions and determining eligibility to benefits.

1.20. The installment number of the return of declaration forms and serial number against which the name of an employee appears on the return of declaration forms should be indicated at the appropriate place on the top of the declaration form of such employee.

1.21. The declaration forms of female employees should be entered in a separate return of declaration forms. The return should also be rubber stamped or marked in red block letters as FEMALE.

Declaration forms in regional language

1.22. It is likely that some employers may wish to send the declaration forms and the returns of declaration forms filled-in in the regional language. This should be allowed provided the writing is legible but the printed documents including identity cards will be prepared either in Hindi (in States where Hindi has been adopted as the Central Government's official language) or in English (in States where Hindi has not been so adopted).

Entry in register under Reg. 32

1.23. While filling declaration forms in respect of an employee, his name and other particulars including the date of his entry in insurable employment should be simultaneously entered in the register in form 6 required to be maintained by the employer under Regulation 32. The insurance number of the IP will be entered on receipt of the return of declaration form from the Branch Office.

Declaration forms of indirect employees.

1.23A. The employees of the immediate employer working in the premises of the factory/estt. or working elsewhere under principal employer's supervision are entitled to all the benefits under the Act and, therefore, it is the duty of the principal employer to submit the declaration forms of all such employees employed by the immediate employer. Further, under Regulation 32 (1) every immediate employer must maintain a register in form 6 in respect of all those employees who are covered under the Act and must submit the same at the time of settlement of his account with the principal employer.

Receipt of declaration forms

1.24. The employer should arrange to send the declaration forms, including the temporary identification certificates, accompanied by the return of declaration forms in duplicate to the Branch Office within the prescribed time limit. When the declaration forms accompanied by the return are received at the Branch Office, the registration clerk should check that all the forms listed in the return have been attached. If any form is missing, a remark should be given to that effect against the name of the employee on both the copies of the return. The registration clerk will then enter the instalment in the combined register of

declaration forms-cum-allotment of Ins. Nos-cum-preparation of documents to be maintained in the following proforma, separate registers being maintained for males and females: -

S. No		Date of return of declaration forms		Name of employer		Code No.	
1		2		3		4	
No. of declaration forms				Insurance Numbers allotted		Date of despatch of temporary identification certificates	Signature of Head Clerk/ Manager
Received	Found defective and returned to employer	Found in order	From	To			
5(a)	5(b)	5(c)	6(a)	6(b)	7	8	

Date of preparation of documents					Date of dispatch of documents					Remarks
Identity cards	MRES	Index Cards (in case of panel system only)	Index sheets	Medical acceptance cards(in panel system only)	Identity cards	MRES	Index Cards (in case of panel system only)	Index sheets	Medical acceptance cards(in panel system only)	
9(a)	9(b)	9(c)	9(d)	9(e)	10(a)	10(b)	10(c)	10(d)	10(e)	11

Date of receipt of declaration forms alongwith RDF will be shown prominently in the middle of the register before making the first entry on each day on which declaration forms are received. The block of insurance numbers to be used as intimated by the Regional Office will be indicated under a proper heading on the first page of this register, to be duly authenticated by the Manager. This register should be properly maintained in every Branch Office and each column containing the date of preparation and date of despatch of each document should properly be filled in and initialled by Head Clerk/Manager.

Checking of declaration forms

1.25. The entries in individual declaration forms will then be checked one by one for omissions, errors and doubtful entries. Each form should be carefully scrutinised to see whether the particulars of family have been fully stated and photograph attached. In particular, it must be seen whether the persons mentioned as family members and shown in the photograph are within the definition of term 'family' with reference to their relationship to the insured person as recorded under the item. Attention should be paid to the legibility of various entries to ensure that each word, letter or figure is read correctly. While checking, it should be borne in mind that all the declaration forms should be clear of every defect before they are allotted Ins. Nos. In case of Declaration Forms filled in a regional language other than in Hindi, the necessary entries required to prepare Identity Card should be translated into English or Hindi. This translation should be made out of the declaration forms on a separate sheet and be authenticated by the BM and should be tagged with the original Declaration Form. If the age has been given but not the year of birth, the latter should be worked out and entered in the relevant column. Every item on the declaration form should be ticked in token of having been checked.

Defective declaration forms

1.26. Defective declaration forms should not, as far as practicable, be returned to the employer but his assistance may be secured to get the defects removed on the spot at the Branch Office itself. Only those forms which have serious defects incapable of being rectified on the spot should be returned to the employer for rectification. Declaration forms received without photographs may not be returned but insurance numbers should be allotted and RDF sent without TICs of such IP's. Clarification or missing information received from employer in respect of defective declaration forms should be attached with each original declaration form to secure authenticity. The entries in the return of declaration forms in respect of those found missing as well as found defective and returned should be scored out with a suitable remark. However, declaration forms without photographs, if otherwise in order should not be returned.

1.27. Defective declaration forms needing correction by an employer should be forwarded to him with a covering letter in form ESIC-121 (Annexure VII). If the employer's reply is outstanding for over 2 weeks, a reminder should be issued. Form ESIC-121 will also mention those forms not being returned (i.e. Forms received without photographs)

Allotment of insurance numbers

1.28. The registration clerk will imprint insurance numbers of each IP simultaneously in the declaration form, the TIC, against his name appearing in both copies of the RDF. He will perform this operation with the help of a numbering machine. While printing the insurance numbers he will invariably ensure that the same insurance number appears on these four documents in respect of each person. He will then make entries in the relevant column of the register described in para 1.24 and pass on all the papers to the checker. The checker will check that –

- a) the insurance numbers have been properly allotted and that they are against the same name at all the four places in the three documents,
- b) insurance numbers are allotted to all the eligible employees,
- c) the insurance numbers allotted to both male and female employees fall within the separate blocks of insurance numbers reserved for them, and
- d) no declaration form has any material defect or omission.

The checker will tick each entry in token of having checked it.

1.29. Every temporary identification certificate except where photograph is not attached will then be authenticated by the Branch Manager by affixing his signature over the words "Issuing Authority" and stamped with his rubber stamp.

1.30. The original copy of the return of declaration forms will be sent back to the employer along with the temporary identification certificates, except where photograph is not attached, after affixing the following rubber stamp on the return within a week of the receipt of the forms in Branch Office: -

Returned.....Sheets R. D. F.
from Ins. No.....to.....
with T. I. Cs.
Manager/Head Clerk

1.30 A. The TICs of those IPs whose family photographs have not been received, will be withheld and will be released by the Branch Office only on receipt of the said photographs, vide para 1.27 above.

1.31 Although a period of one week has been provided for allotment of insurance numbers on declaration forms and for returning the temporary identification certificates in respect of fresh entrants to the employers, the Branch Office should endeavour to organize this initial part of registration in such a way that all the steps up to the issue of temporary identification certificates are taken on the spot at the time of receipt of return accompanied by the declaration forms and the temporary identification certificates along with the original return are handed over to the person who brought the declaration forms to the Branch Office. This will save the Branch Office of the botheration to dispatch them as also ensure quick delivery of temporary identification certificates to the concerned IPs. The only exception to this recourse should be in respect of declaration forms received by post for which the Branch Office must make its own arrangements for delivery of the return as well as the temporary identification certificates either through the Branch Office messenger or by post within the stipulated period of one week.

1.32 The return when received by the employer will serve as an acknowledgement of declaration forms besides enabling him to insert the insurance numbers in the register in form-7. (form 6 w.e.f. 1.1.05)

1.33 The TICs will be distributed by the employer to the employees concerned TICs of those who have left employment will be returned to the Branch Office.

ESIC-86 by employer

1.34. If the temporary identification certificates are not received and an insured person or a member of his family needs medical treatment in the meantime, employer should issue him a certificate of employment in form ESIC-86 giving therein the names of his family members also. This certificate of employment will also be valid for treatment etc. for a period of three months from the date of entry of insured person into insurable employment. Certificate of employment may also be issued to an insured person who has lost or torn or mutilated his temporary identification certificate. However, in case certificate of employment has been issued, the temporary identification certificate, if received later from the Branch Office, should not be issued to him.

Revalidation of temporary identification certificate

1.35. Where an employee, having continued in the service of the employer over 3 months, does not receive his permanent identity card, the employer may revalidate the TIC for a period of three months by endorsing on it 'Revalidated upto

1.36. Sometimes submission of declaration forms of new entrants is delayed so much by the employer that the temporary identification certificates when returned by the Branch Office may have already become invalid, the period of three months for which it is valid from the date of entry having already elapsed. This puts the insured persons to a great hardship. For such cases, where the employer sends a declaration form after a period of 2-1/2 months from the date of entry into insurable employment, he should indicate on each such declaration form whether the IP is still in his service. The temporary identification certificates of such persons will be validated by the Branch Manager over his signatures from the date on which the IP was still in employment as per employer's remark in the declaration form. The temporary identification certificate so validated will as usual be sent to the employer alongwith the return of declaration forms for delivery to the insured persons and those shall be valid for 3 months from the date of validation.

Maintenance of declaration forms

1.37. Duplicate copies of the return of declaration forms retained in the Branch Office should be filed chronologically in employer-wise files maintained at the Branch Office. The declaration forms should be kept in strict insurance number order in loose file covers 2 cms. larger in length and width than the size of declaration forms, and bound in convenient bundles and stitched with a strong thread through 3 holes on the left side. The bundles should be kept at a safe place.

Writing of documents

1.38. As per Regulation 103 A (1), a person on becoming an insured person for the first time shall be entitled to medical benefit for a period of 3 months. The temporary identification certificate sent to the employer can be utilised by an insured person for obtaining medical benefit for himself and his family members for a period of 3 months from the date of his entry into insurable employment. Every person who continues for 3 months or more to be an employee of a covered factory/establishment, is entitled to medical benefit till the beginning of the corresponding benefit period. Proof of whether he has continued for 3 months or more in insurable employment lies in his possession of a permanent identity card. Due care has, therefore, to be taken by the Branch Office to ensure that permanent identity cards are issued by the employer only to those persons who have remained in his employment for 3 or more months. Preparation of documents such as the identity card etc., should be done by the Branch Office and despatched to employers in such a way that these can be distributed by the employer to those of his employees only who are continuing in his service on the expiry of 3 months from the date of their entry into insurable employment.

1.39. The following documents will be prepared by registration clerk: -

- (i) **IDENTITY CARD** with family photo of the IP which will be affixed or stapled on the back of the card and duly authenticated by the Branch Manager with his signature and rubber stamp. Remarks of having prepared photo identity card should be given on top of declaration form.
- (ii) **MEDICAL RECORD ENVELOPE** for the insured person in blue colour and for the insured woman in pink colour. (specimen at annexure VIIIA)
- (iii) **INDEX CARD** one copy-only for areas where medical care is provided through panel system.
- (iv) **INDEX SHEET** (specimen at annexure VIII).
- (v) **PERMANENT ACCEPTANCE CARD** for those areas only where medical care is provided through panel system.
- (vi) **SINGLE MEDICAL RECORD ENVELOPE** for family members in which medical record card for each member will be inserted. Specimen at Annexure VIII A.

1.39A. It has been decided that “number daters” should be used for stamping the insurance numbers on all the documents prepared instead of writing the same in hand (Please also refer to paras 1.28 and 1.44). In the light of this decision, it has become imperative for every Branch Office to obtain and maintain a “number dater” for use in preparation of registration documents. Further, the name of every insured person should be written in every document in legible block letters and in no case in small letters. Preferably, the documents should be prepared and written in black ink tracing pen in neat hand.

1.39B. In places where medical care is provided through panel system the index cards will be prepared first by copying the particulars from declaration forms. The identity card and permanent acceptance card will then be copied from the index card. In areas served by service (dispensary) system, the identity card will be prepared first and an index card or permanent acceptance card will not be prepared. The first document prepared in each case will be checked by the checker who will initial in top left hand

corner thereof. All identity cards prepared will be signed by the BM who will also affix his rubber stamp below his signature. For either area, both medical record envelopes (for IP/IW and for family) will be prepared. The name of the IP will be written *in every document in legible block letters* and other particulars will also be filled in with great care. Overwriting should be avoided. All documents other than the identity card will be authenticated with the special metallic stamp of the Branch Office.

1.39C. The family photograph of IP should be attached/stapled properly on other side of the identity card.

Despatch of documents

1.40. When the documents as indicated above are ready, these will be sorted out as under: -

- | | | |
|-------|-----------------------------------|---|
| (i) | Identity card | Employer-wise. |
| (ii) | MREs for IP & family | In service system, dispensary-wise. In panel system to be arranged in Ins. No. order for despatch to AMO through R. O. |
| (iii) | Index card (only in panel system) | Arranged Ins. No. wise, for despatch to AMO through R. O. |
| (iv) | Index sheet | Ins. No. wise - for despatch to R. O. (103-A Section) or to designated Branch Office, as the case may be (see para 13.2.A) for completion of entries in ESIC-38 registers |
| (v) | Permanent acceptance card | Employer-wise |

The Branch Office will then make bundles for each destination and also prepare the challans forwarding these documents in forms noted against each.

Identity Card and permanent acceptance card(where applicable)	In form ESIC-125 (copy at annexure IX) separately for each employer, to be prepared in duplicate. Branch Office must emphasise on obtaining IP's signature on the identity card before it is handed over to him by the employer.
Index cards and MREs for IPs/IWs and family members, in areas served by panel system.	Under single challan in duplicate in form at annexure X with separate bundle of documents for AMO through Regional Office.
MREs of IPs/IWs and their family members for each dispensary (under the service system).	Under challan in duplicate in form at annexure X separately for each dispensary.
Index sheet	To be enclosed to monthly progress report of the Branch Office if ESIC-38 registers are maintained at RO; otherwise to be sent to designated Branch Office and monthly progress report alone will be sent to RO.

Date of despatch will be recorded in the Branch Office register described in para 1.24, which will be duly authenticated under the initials of Head Clerk/Manager.

Ledger sheet

1.41. In addition to the above mentioned documents, a ledger sheet has also to be opened by the BO in respect of every IP/IW. In the decentralised system wherein all registration work is performed at the BO, a ledger sheet is not to be prepared simultaneously alongwith other documents, but it is to be opened only when an IP sends his first claim or certificate or submits an application for a duplicate identity card. Separate forms of ledger sheets in form L-1 and L-2 should be used for male and female, respectively. Each ledger sheet when opened should be authenticated with the signature of the BM, with a simultaneous entry in the declaration form "Ledger sheet opened on", which should be also attested by the Manager. In case a duplicate photo identity card is being issued, a note to this effect should be given in the ledger sheet.

1.42. In areas where registration work is centralised, each Branch Office receives sheets containing adrema impressions of particulars of IPs employed in factories/estts. allotted to it. Usually, the bundles of declaration forms are also sent to the Branch Office. Action for opening a ledger sheet is taken by the Branch Office in the same manner as in the case of a Branch Office functioning in an area of decentralised registration.

1.43. Ledger sheets are to be kept secure inside loose-leaf binders provided for the purpose or under bound covers as may be considered desirable by the RD. Each binder has the capacity to take in over 500 ledger sheets. However, for the sake of convenience, only about 250 ledger sheets should be inserted initially with provision for inserting additional sheets for intervening insurance numbers and also continuation sheet where necessary. Every newly opened ledger sheet should be inserted in the binder at the appropriate place in the sequence of insurance numbers.

1.44. A new ledger when brought into use should be page-numbered with the numbering machine. When a new ledger sheet is inserted at the proper place in the sequence of insurance numbers, its page number should be the same as borne on the preceding ledger sheet, but distinguished by addition of 1, 2 etc., within brackets. Thus, if a new sheet is inserted next after ledger sheet page No. 40, the new sheet should be given page No. 40(1). If a further ledger sheet after page 40(1) but before page 41 is inserted, it should be numbered 40(2). The Manager should, before initialing the new ledger sheet or attesting entry in declaration form, satisfy himself (by a check of the declaration form as well as the index sheet in the ledger) that a ledger sheet has not already been opened. He should also keep the stock of blank ledger sheets under his safe custody.

1.45. When the first page of the ledger sheet of an IP is fully used up, the page on the reverse should be used. However, before commencing entries on the second page, both name and insurance number of the insured person should invariably be entered on top left side, when the page on reverse is also exhausted, a continuation sheet should be inserted next after it. Continuation sheet is given the same page number as the original one, but with the addition of 'A' or 'B' etc. to distinguish it. The continuation sheet should also be signed by the Manager before starting entries on it.

1.46. All ledgers should be serially numbered and on the cover of each ledger should be written the first and last Ins. Nos. contained in it. Each Branch Office will maintain a list of ledgers, showing the serial number of each ledger and the range of insurance numbers covered by it (first and last insurance numbers).

1.47. Every ledger should carry an index in Form L-3. Two sheets of blank index forms L-3 as per specimen below should be inserted next to the binder, with the ledger sheets following. Every ledger sheet should be entered in the index. The entry in the index should also be duly attested by the Branch Manager at the time new ledger sheet is inserted. Entry should indicate S. No., Ins. No. and page no.

Columns in the index for original ledger sheets are separate from those reserved for subsequent insertions. Original sheets will be numbered on the index in the sequence of Ins. No. and subsequent insertions can normally be entered chronologically.

Form L-3

Index						Index					
			Subsequent insertions						Subsequent insertions		
Sr. No.	Ins. No.	Page No.	Sr. No.	Ins. No.	Page No.	Sr. No.	Ins. No.	Page No.	Sr. No.	Ins. No.	Page No.
1	2	3	4	5	6	1	2	3	4	5	6

Normally blank forms L-3-index sheet – will be supplied by the Regional Office. However, in case of shortfall in supply, the above columns can be easily reproduced with the help of a pen and ruler but it is inescapable to have the index sheet in every ledger.

1.48. On the transfer of an insured person to another Branch Office an attested copy of ledger sheet will be sent by the previous Branch Office to new Branch Office. The Manager of the Branch Office transferring the entries to the ledger sheet through an attested copy should cancel the original ledger sheet over his dated signatures under the remarks “Transferred to Branch Office”. The attested copy of the ledger sheet so received will be inserted at the relevant place in the ledger of the new Branch Office. The new ledger sheet shall be duly page numbered in the manner mentioned above.

1.49. As and when an IP calls on the Branch Office for the first time the counter clerk or the receptionist will write the ledger folio and ledger number on his identity card. Such a step will facilitate tracing out of a ledger sheet without reference to the index during his subsequent visits to the Branch Office.

1.50. Every precaution should be taken by the Manager to prevent fraudulent payments which have come to light particularly in the payments of benefits by money order. Some inbuilt preventive steps are listed below: -

- (i) The signature of the insured person should be obtained on the ledger sheet in the space provided. Since the signatures will not be attested by the employer, the Manager has to be very cautious so that the signatures obtained are of the genuine insured person whose photograph is affixed on identity card and that they tally with those on his identity card. Signatures recorded on the declaration form should also be taken out at times for comparison.
- (ii) During working hours of the Branch Office, the ledgers will be kept in a rack by the side of the counter clerk from where they can be picked up and replaced. At the close of business for the day the ledgers should be kept under lock or otherwise under safe custody. For this, the Regional Director may make proper arrangements by providing the furniture/equipment, as may be considered desirable, under his own powers, or in consultation with the appropriate authority as the case may be.

- (iii) Utmost care is to be taken in the upkeep of ledgers in fine condition so that no page/ledger sheet gets loosened or lost. Loss of a ledger sheet is fraught with risk of fraudulent payment or overpayment. The Branch Manager has to take personal interest in this important aspect of maintenance of ledgers and when he finds that there is danger of sheets coming out due to damage to punch holes, he should take steps to get the same bound in the form of a register. Responsibility is to be fixed for loss of ledger sheets from the binder.

1.51. For facility of movement of ledgers, as far as possible, running counters should be provided in every Branch Office. Laminated/sunmica top may be used on top of running counters (of 4' length) as well as on top of rack having the stock of ledgers in all the Branch Offices. However, the laminated/sunmica sheet should be fixed on wood other than that of expensive variety like teakwood etc. and the work be got done after following the usual procedure in consultation with the respective Dy. Director (Finance).

Mass registration on 'Appointed Day'

1.52. A number of steps precede mass registration of coverable employees in an area as briefly enumerated below:

- (1) Surveys to determine those units which may be amenable to coverage and to make an estimate of the number of coverable employees in the area.
- (2) Survey of residential concentrations of labour for setting up dispensaries at suitable places.
- (3) Arrangements by the State Government for providing medical care to insured persons and their families including setting up of dispensaries, posting of staff, stocking of medicines, arrangements for X-Ray, laboratory, specialist examinations, hospital care, etc.
- (4) Determining the precise area of implementation.
- (5) Decision on date of implementation of the Scheme by headquarters in consultation with State Government and the Regional Director.
- (6) Setting up Branch Offices etc. and provision of staff by the Corporation.

The Central Government is then approached to issue a notification under Sec. 1(3) of the Act extending provisions of the Act to the area. The Scheme comes into force from the date mentioned in the notification issued by the Central Government which is published in the Gazette of India.

1.53. When the State Government decides to extend the Scheme to certain establishments in the area in exercise of its power under Sec. 1(5) of the Act, the existing facilities for provision of medical and cash benefits are reviewed and augmented where necessary as a result of a fresh survey of coverable establishments in the area and on ascertaining the number of coverable employees.

1.54. About 2 months before the expected but firm date of implementation of the Scheme to factories in an area or subsequent extension to establishments in the area, the Regional Office will initiate the process of registration by the allotment of code numbers to all new factories/establishments found amenable to coverage as a result of survey carried out. It will issue a circular letter to these factories/establishments as well as to those covered factories in the area which were allotted code numbers earlier but were treated as uncovered after the repeal of Chapter VA of the Act with effect from 1.7.1973. The circular letter will be accompanied by samples of declaration forms, return of declaration forms, return of contributions, form 6 under Reg. 32, challan form, etc., which will require to be filled up by the employees and/or the employers at the time of registration or payment of contribution. They should be specifically requested to advise their employees to arrange a set of their family photos for affixing the same on TIC/PIC. This will enable the employers of the area to know the volume of work they are expected to

do, so that they may make necessary arrangements for staff etc. in advance. The Regional Office will despatch sufficient quantities of forms to the Branch Office immediately alongwith a list of coverable factories/establishments in the area.

1.55. About the time the circular letter is issued by the R. O. to the employers, blank forms such as those mentioned in the preceding para meant for the employers, will be sent by Branch Office to every listed employer. The number of forms to be sent will be equal to the estimated number of coverable employees in the factory/establishment plus about 10% allowable for wastage. Each bundle of forms will be accompanied by a challan in duplicate in form ESIC-120 (copy at annexure II), one copy of which should be received back duly acknowledged from the employer. The Branch Office will maintain a blank forms stock register in the form at Annexure-I.

Time table for registration

1.56. The Regional Office will indicate to the Branch Office a time-table for completing the various stages of the work. Branch Office should, in conformity with the timetable, work out detailed programme fixing targets for the individual employers and for the Branch Office as a whole. It is the responsibility of the Manager to watch progress in the execution of the programme. He should allot field work to some of the officials in the Branch Office. The area of implementation can be divided into zones, one zone to be fixed for a convenient group of factories. Different officials in the Branch Office can be assigned different zones. It will be the duty of each field official to keep a watch over the progress of registration in his zone. Whenever any employer's work is found to be falling behind the schedule, the field official and, if necessary, the Manager should personally contact the employer.

Training of employer's staff

1.57. In order to ensure completion of registration work in time and to acquaint the employer's staff with their responsibilities and duties under the Act, a training programme should be organised to train those officers and staff of employers who will be responsible for work under the Scheme. Employer's guide may also be supplied, if available, to employers.

Publicity

1.58. At about the same time as the circular is issued, Regional Office and the Branch Manager should take adequate steps to give wide publicity to the implementation of the Scheme. This could be done by displaying posters designed for this purpose in labour areas, employer's premises and the offices of the trade unions etc. Meetings of the employees and of the works committees at the factories and those sponsored by reputed trade unions should also be addressed. While addressing such meetings, the location of Branch Offices and dispensaries, panel doctors and the particulars to be completed on the declaration forms should be explained. Copies of pamphlets on the Scheme should be distributed and other mass media may be utilised for educative publicity. This will enable the employees to be ready with the necessary information to be given on the declaration forms and two copies each of their postcard size family photographs to be affixed on TICs/PICs.

Declaration forms in instalments

1.59. In the case of large employers it will be convenient for them to send the forms at the time of initial registration in instalments, as and when they are filled in. An employer who sends the declaration forms in instalments should be advised to prepare the return of declaration forms, excepting the final one, on continuation sheets. An instalment should not ordinarily contain more than 200 declaration forms. The employer should indicate the serial number of each of these instalments on both copies of the return in red block letters. The instalment numbers should run in a serial order beginning from 1, and the serial no. of employees on the return should not be broken at the end of any instalment but should be continued from instalment to instalment so that there is continuous serial number covering all employees.

Forms of recalcitrant employees

1.60. Completion of declaration forms in respect of employees who refuse to disclose their particulars, or refuse to sign, presents considerable difficulties. Such a situation requires tactful handling and calls for immediate action by the Branch Manager. The following steps may be taken to bring round recalcitrant employees:

- (a) Efforts should first be made through their employer to persuade them.
- (b) The good offices of their trade unions may be used to win their co-operation.
- (c) The Branch Manager may personally make contact with employees to answer their objections and to explain to them the purpose of registration and of the Scheme. Distribution of a few copies of printed pamphlets on the Scheme may also be helpful.
- (d) Branch Manager may report the matter to the Regional Director for guidance and help.
- (e) If the employees persist in refusal even when all the above methods have been applied, the Branch Manager may ask the employer to complete declaration forms with whatever particulars that are available in his records. Such declaration forms may be sent by the employer to the Branch Office without the signature of the employees. Such forms may be rubber stamped or marked 'not signed by the employee' to distinguish them from other forms and these forms sent alongwith a return in duplicate whereon Ins. No. may be allotted to them. Identity cards will not, however, be prepared. If any of these employees calls in the Branch Office, he should be asked to get a freshly completed form duly counter-signed by the employer alongwith family photograph of the IP which may be pinned with the earlier form and documents prepared and identity card issued to the insured person if he continues in employment for 3 months or more, on taking his signature on the declaration form. T. I. C. should be destroyed in such a case.

Persons leaving service before A-day

1.61. Since registration is commenced in advance of the Appointed Day, some employees in respect of whom declaration forms have been completed may go out of employment before the Appointed Day. The employer should cancel the declaration forms of such employees. In case the forms have already been submitted to the Branch Office, information of cessation of employment in writing, giving full details about all such employees should be sent by the employer alongwith the temporary identification certificates/identity cards lying with him in respect of such employees, a week before the Appointed Day. The Insurance Nos. of these persons will be traced at the Branch Office and index cards, temporary identification certificates, identity cards lying there will be destroyed. The declaration forms will be rubber stamped "Cancelled" and the Dispensary and the Administrative Medical Officer will be advised to destroy the printed documents if already sent to them in respect of these persons.

Action where more than one form filled in

1.62. In the case of big factories where number of employees is very large, it is possible that due to the transfer of an employee from one department where registration had been completed to another where it is still in progress or due to any other reason, more than one declaration forms may be filled in in respect of the same employee. It is very difficult to detect such a case at the Branch Office. But whenever such a case comes to notice, the employer may be requested to clarify. If the employer confirms that two or more insurance nos. have been allotted to the same person, only one Insurance No. will be retained and the other cancelled. The documents printed under the other insurance no. will be destroyed in the manner stated in the preceding para.

Progress report on registration

1.63. The Branch Office will send a progress report of registration to the Regional Office in form to be prescribed by the Regional Office. The report will be examined at Regional Office to see whether Branch Office is adhering to the targets fixed for it in the Regional Office timetable.

Action by employer/IP on documents received

1.64. After an employer has sent a batch of declaration forms he will in due course receive in respect of them the following documents: -

(i) **Temporary identification certificates:** These will be returned by the B. O. alongwith the original return of declaration forms within 7 days of receipt of declaration forms after allotting insurance numbers on them. These should be distributed by the employer to the employees who are still in his employment on the A-Day.

(ii) **Permanent identity cards etc.:**

(a) On receipt of permanent identity cards which will be duly accompanied by a card-size photograph of each IP stapled to each and, in panel areas, also of the permanent acceptance cards from the BO, the employer should issue those documents to such of his employees as have been in his employment continuously or otherwise for broken periods adding up to 3 months. While issuing a permanent identity card (and permanent acceptance card), the employer should obtain the signature or thumb impression of the IP on each card, and he should also obtain signed acknowledgement for the receipt of these documents in a register to be maintained by him.

(b) The permanent identity cards and permanent acceptance cards of insured persons who have left employment before the expiry of three months after the A-Day should be returned by the employer to the Branch Office where these will be retained for one year.

1.65. Every insured person should present his temporary identification certificate or certificate of employment or permanent identity card and in panel areas, also the permanent acceptance card at the ESI dispensary or the Insurance Medical Practitioner's clinic where he will get medical treatment for the period of validity.

Permanent acceptance card

1.66. A permanent acceptance card is valid for presentation to an Insurance Medical Practitioner for 10 months. If presented after this time limit, it should be supported by a certificate of employment in form ESIC-37. If the insured person is not in insurable employment 10 months after his entry, and needs medical treatment for the first time, he should apply to the Regional Office/Branch Office, who will revalidate his permanent acceptance card for the period, if any, for which he has title to medical care.

Temporary acceptance card

1.67. Every Insurance Medical Practitioner has in his stock a few blank cards of blue colour known as temporary acceptance cards. When an insured person who has neither received his permanent identity card nor permanent acceptance card approaches him for treatment, the Insurance Medical Practitioner should affix his rubber-stamp on the temporary identification certificate/certificate of employment presented to him and prepare a temporary acceptance card in respect of the insured person stating therein the name, Ins. No., and the date of entry of the insured person into insurable employment as also the date on which he has accepted the insured person. He will send the temporary acceptance card to the Administrative Medical Officer (for the purpose of payment of capitation fee). On revalidation of a temporary identification certificate or a certificate of employment, the Insurance Medical Practitioner should put his dated signature on it and simultaneously issue to the Administrative Medical Officer another

temporary acceptance card, this time marked "Extension" which will entitle him to capitation fee for another quarter.

Registration of employees of OD prone industries

1.68. In the light of the Hon'ble Supreme Court judgement dated 27-1-95 in a public interest litigation, the following action is to be taken by Regional Office/Branch Office/IMO in r/o registration of new entrants of OD prone industries covered under the Act: -

- (i) Regional Director may identify the industries which are prone to occupational diseases. For this, the First Schedule to the Factories Act, which contains a list of industries involving hazardous processes, may be an indication where to look for OD prone industries. A copy of the said First Schedule has been reproduced as Annexure I to Chapter IVA-Temporary Disablement Benefit Procedure (Occupational Diseases).
- (ii) Such factories which are covered under the ESI Scheme, should be given a distinct code number for identification.
- (iii) Medical examination may be prescribed at the time of first entrance in these specially coded industries and a copy of the first medical report be kept in the concerned ESI Dispensary in MRE of such insured persons.
- (iv) A distinct red-colour identity card may be issued to the workers working in these industries. Similarly, MREs of these workers should also be of distinct red colour. To begin with, however, a red – colour strip may be pasted on the identity card as well as on the MRE. The slip will contain the legend "ODP" (OD prone).
- (v) As and when any such worker visits the dispensary, he is required to bring a copy of the medical report prescribed under Section 87 of the Factories Act, 1948 read with Rule 120 of the model rules made thereunder. This will help IMO to examine the person in relation to the specific risk involved in that industry.
- (vi) A proper base health report, clinical findings and investigation reports be drawn on his first attendance to the dispensary and preserved for future reference.
- (vii) If at any stage, the insured person is suspected to have manifested signs and symptoms of occupational disease specific to his risk involved, he may be referred to the Occupational Disease Centre alongwith the detailed report of his previous investigations and subsequent status for further examination/evaluation which would help early detection of the occupational disease. For details, please see chapter IVA-TDB Procedure (Occupational Diseases)

Registration of employees of branch/sales/head office

1.69. Employees working in the head office, branch office and sales offices of a factory/estt. situated in an area wherein the ESI Scheme is implemented, also become coverable under the Act. Therefore, the employer should take up the registration of these employees simultaneously with the registration of employees of his factory. The factory may have its head office/branch office/sales office not only in the same implemented area but also in some other implemented area and possibly also in another State. The following guidelines should be followed by the B. O./R. O. as well as by the employer for registration of the employees of these offices:

- (i) The Manager of the Branch Office to which the factory/estt. is attached should not accept the declaration forms of employees employed outside the area of his Branch Office. Instead, he

should ascertain the details of all these offices including the full address of each, the number of employees working in each, monthly wages of the employees working in them, etc. and intimate them to the R. O. At the R. O., a separate ledger page will be opened in respect of each of these offices. The same code number as of the factory will be allotted to each. Out of these, for offices situated in its own jurisdiction a distinguishing suffix mark such as H. O./B. O./S. O. will be added at the end and intimated by R. O. to the factory/estt. indicating therein the B. O. to which these employees will be attached for claiming cash benefits. A list of dispensaries in the area will also be forwarded to the employer to enable employees of the said office to opt to one of their choice. A copy of R. O. letter will be endorsed to both the Branch Offices.

- (ii) Regional Director of the area where factory/estt. is situated will address intimations in respect of H. O./B. O./S. O. situated outside his region to the RD of each of the areas in which these are situated, asking them to take necessary action for registration of employees and recovery of contribution. The R. O. of the area where such office is situated will open a separate ledger sheet, allot it the same code number as of the parent factory/establishment and add a suitable distinguishing suffix mentioned above. This R. O. will take action similar to that mentioned in item (i) above for registration of employees of these offices as also for watching the recovery of contributions. A copy of the intimation letter will be endorsed to the Regional Office of the area in which the factory/estt. is situated.
- (iii) The employer of parent factory/estt. should be advised to maintain separate records of wages, submit separate returns of contributions and as far as possible make payment by separate challans to the Account No. 1 of the region in which each such office is situated. Photocopy of the challans should be sent by such office to the parent factory/estt. for verification at the time of inspection.
- (iv) The ES9 Branch Manager of the area in which the HO/BO/SO of the factory/estt. is situated will also receive intimation about these offices from his Regional Office. He should provide all the guidance to the incharge of the said office about filling up of declaration forms, maintenance of register in form 7 (form 6 w.e.f. 1.1.05), choice of dispensary etc. and to afford all necessary co-operation for registration of the employees, issue of permanent records and payment of benefits on the strength of return of contributions which would be received at his Branch Office direct from the incharge of such a Head Office/Branch Office/ Sales Office (see para 13.1.2) or received from his Regional Office.
- (v) If the head of the Branch Office etc., fails to submit the declaration forms of covered employees working under him, the Branch Manager should take the usual action described for failure to submit declaration forms as described in Para 1.13. If he does not receive the forms or satisfactory evidence that these forms have already been submitted by the principal employer of the covered factory/establishment, he should inform the R. O. Prosecution action for non-submission of these forms will be taken by the Regional Director of the area in which the factory/establishment is situated.

Registration of families at a place other than the place of work of the insured person

1.70. The Standing Committee/Corporation at their meetings held on 23/24-2-78 extended the facility of provision of medical benefit to members of family residing away from the place where insured person works provided both the places are implemented centres and located in the same state. The registration procedure to be followed to facilitate provision of medical benefit to the insured person at the place of his work and to the family at the place of their residence will be as follows:

- (1) So as to enable the family to possess a temporary identification certificate, it will be necessary to provide two temporary identification certificates, one for the insured person and the other for the family. For this purpose loose forms of TICs (Specimen at annexure-XI) may be got printed and supplied to the employers. The printing may be got done on yellow paper in

black ink. On the front right side of this form the words “ONLY FOR FAMILY MEMBERS NOT RESIDING WITH IP” may be got printed in bold letters.

- (2) An up-to-date list of all the dispensaries, hospitals, panel doctors, employer’s utilisation dispensaries, mobile dispensaries etc. may be obtained from the Director Medical Services / Administrative Medical Officer of ESI Scheme in the State and the same may be circulated to all the employers/ displayed at the Branch Offices. This will enable the family members to select the dispensary / Insurance Medical Practitioner of their choice, and the same may be entered by the insured person in the temporary identification certificate.
- (3) The declaration form of such IPs should be accompanied by an additional TIC(See Annexure XI) and two photographs each of IP and his family. On receipt of both the TICs one attached to the declaration form and the other loose as per para 1 above duly filled in from the employer alongwith two separate sets of photographs, one of the IP and the other of the family, the same may be signed by the competent authority in the Regional Office / Branch Office. The columns for the family particulars on the back of the TIC meant for the insured person may be defaced with a rubber stamp “FAMILY NOT RESIDING WITH THE IP”. Photograph of the family should be attached with the loose T.I.C. meant for the family.
- (4) Both the TICs, duly completed and signed may be delivered to the IP through the employer, and the insured person will himself arrange to deliver the TIC to his family. Before delivery of TIC an entry regarding family dispensary may be made in column 11 of declaration form by way of remarks.
- (5) The procedure for revalidation of TIC will be the same as is being followed and it will be the insured person’s responsibility to get the same revalidated, if the need so arises.
- (6) Two permanent identity cards will have to be issued, one for the insured person bearing his photograph and other for the family bearing their photograph. As in the case of TIC it may be ensured that the insured person/family may be able to take treatment at only one centre on the basis of separate permanent identity cards issued to each. For this purpose the family permanent identity card may be got printed separately on yellow card in black ink and the same measures, as described in (3) above, may be taken.
- (7) If the registration is done at the Regional Office, before delivery of permanent identity card (for family) an entry may be made in the remarks column of ESIC-38 register to the effect “Family attached to dispensary”. These remarks may be attested by the Head Clerk or incharge of the concerned branch of the Regional Office.
- (8) Where registration is done at the designated Branch Office, the Manager will send a list in duplicate of all such insurance numbers and the name of dispensary to which the family is allotted, to the Regional Office/designated Branch Office for which family identity card has been prepared as in (6) above. This list will be forwarded every month alongwith the monthly progress report to which index sheets are also attached. For this purpose the Branch Office will maintain a register indicating the name and insurance number of the insured person, name of the dispensary to which the family is attached and the date of preparation of the family identity card. Before delivery of the identity card, the Branch Office will make an entry in this register and the same will be attested by Head Clerk or the Manager as the case may be. The Branch Manager will certify in the register “Particulars from Sl. No.to.....have been sent to Regional Office/designated Branch Office”, at the end of every month.
- (9) After receipt of the particulars in the Regional Office/designated Branch Office, entries shall be made in ESIC-38 register as per (7) above.

- (10) The medical record envelope is to be sent to the dispensary/Insurance Medical Practitioner to which the insured person is attached, and the MRE for family members is to be sent to the dispensary/Insurance Medical Practitioner to which the family is attached.
- (11) In panel areas two permanent acceptance cards may be issued one for the family and the other for the insured person.
- (12) In case an exit card is to be issued, it will be necessary to prepare two copies of it, one to be sent to the ESI Dispensary/Insurance Medical Practitioner's clinic to which the insured person is attached and the other to the dispensary/IMP's clinic to which the family is attached.

Registration of families residing in another state

1.70A The Standing Committee and the ESI Corporation, at their meetings held on 19/21-2-2003, approved the proposal to extend medical facilities to those families which reside in a state different from the one in which IP is employed, provided the family resides in an implemented area in the state of their residence. The cost of medical care to the IP in one state & his family in another state would be equally shared between the governments of the two states. The procedure described below shall be followed to enable IPs & their families to avail of these facilities:

- (i) An IP desirous of availing medical care under the ESI Scheme for his family residing in another state will be asked by the Branch Office to submit an option form as per specimen at Annexure XII.
- (ii) On receipt of IP's option, two separate permanent photo identity cards will be prepared by the Branch Office :
 - (a) for the IP himself on form 4 with the inscription in bold letters: **FAMILY NOT RESIDING WITH THE IP.**
 - (b) for his family on form 4A with the inscription in bold letters: **ONLY FOR FAMILY MEMBERS NOT RESIDING WITH INSURED PERSON**

Two MREs, one for the IP and another for the family (having MRC of each member inserted in it) will also be prepared.

- (iii) Both the identity cards as well as the two MREs will be handed over to the IP who will dispatch the family identity card and the MRE to his family. He will retain his own identity card with himself and hand over his own MRE to the dispensary of his choice.
- (iv) The Branch Office will write to IMOs in charge of both the dispensaries concerned as in Annexure XIII to register the IP & the family with them under intimation to the Branch Office, Regional Office and the AMO.
- (v) The Branch Manager will also send the live lists of such families as in Annexure XIV before start of each benefit period to the concerned dispensary with which the family is registered, under intimation to the Regional Office of the state/area in which the dispensary is situated so that the total number of family units taking medical care in that state / area may be considered for payment on account of expenditure on medical care to the state government (numbers to be counted at the time of working out approved number of IPs as on 31st March every year). The Regional Office / designated Branch Office in both states will make entries in the remarks column of the ESIC-38 register to this effect.
- (vi) The Branch Office to which the IP is attached, will also regularly inform the number of such families residing in another state, to the Regional Office. Likewise, the dispensaries where the families of such IPs are registered shall also invariably inform the Branch Office, Regional Office and the AMO about number of such registrations.

- (vii) Separate family identity cards will be issued only once in a financial year and will remain effective till the end of the said year. Any change for transferring such record to another state will be effected only in next year.

Change in name

1.71. (i). Changes in spelling of names should not be considered as a change in name as Indian names are spelt differently in English by different persons in the same State. Similarly, where an insured person adds or omits his Christian name, middle name or surname, this need not be treated as a change in name. The following example is given to clarify the matter:

Suppose the declaration form of an insured person shows the name as “Prem Chand Ram Chand” and the insured person signs his name as “Prem Chand Ram Chand Agarwal”. Such change does not amount to a real change.

- (ii) In cases where there is a real change in name, i. e., where he renounces part or whole of his name and assumes a new name, an affidavit should be called for. The affidavit should be sworn before a magistrate, notary public or an oath commissioner. The affidavit should be on non-judicial stamp paper of the required value as per prevailing rules of the State.
- (iii) However, in cases where the insured person produces a certified extract from the State/Central Government Gazette notifying changes in his/her name duly countersigned by his/her employer, this may be considered as sufficient for giving effect to changes in the records and no affidavit may be insisted upon.
- (iv) As a woman employee generally changes her name/surname on marriage the following procedure may be adopted:
 - (a) **Under centralised registration:** On receipt of a request for change in name duly supported by a certificate from her employer, name and/or surname be changed in her identity card which should be returned to the insured woman for safe-keeping. The change will be intimated to Regional Office where adrema plate will be corrected and a new identity card will be prepared and sent to the Branch Office. This will be handed over to the insured woman in exchange for the old corrected card which will be destroyed.
 - (b) **Under decentralised registration:** A new identity card incorporating the required changes will be prepared at the Branch Office and handed over to the insured woman in exchange for the old one.
 - (c) The above procedure will not apply to cases covered under items (ii) and (iii) above.
- (v) Where any mistake is brought to the notice of the Corporation by the employer himself, say because of certain mistakes which might have crept into a declaration form, changes made in the Branch Office records should be duly intimated to the employer through letter in form ESIC-54 under intimation to all the parties mentioned therein.
- (vi) Changes above mentioned, when effected, will be made in the Branch Office records, viz., declaration form, ledger sheet, etc. and intimated to all concerned in form ESIC-54.

Change of dispensary/Branch Office

1.72. (i) Where an insured person changes his residence and applies for a change in his dispensary, he should apply in form ESIC-53 at the Branch Office/dispensary or at the new dispensary.

- (ii) If he applies at the new dispensary, the IMO Incharge will inform all concerned in form ESIC-54 and call for the MREs of IP and his family from the old dispensary.
- (iii) If he applies at the old dispensary, change of dispensary will be effected provisionally by the IMO Incharge of the old dispensary. The IMO I/C of old dispensary will inform all concerned in form ESIC-54 and send MRE of IP as well as of his family to the new dispensary.
- (iv) If the insured person applies at the Branch Office for change of dispensary on the grounds of change of residence, the Branch Manager will effect the change provisionally and inform all concerned in form ESIC-54 and will also request the old dispensary to send the MRE of IP and his family to the new dispensary.
- (v) Change of Branch Office should not be allowed on change of residence. Change of Branch Office is effected only on change of employment provided his new employer is attached to a different Branch Office. The new employer will direct the IP with a letter to approach the new Branch Office which will call for his record from the old Branch Office. Code No. of new employer will be inserted in his identity card. On receipt of records from the previous Branch Office a new Ins. No. from out of the block of Ins. Nos. allotted to the new BO will be allotted to him and a new identity card bearing the new Ins. No. will be issued to him in lieu of the old card in the same manner as in the case of inter-regional transfer. The Regional Office/designated Branch Office will also be informed so as to make entries in ESIC-38 register with cross reference to the old Ins. No. All concerned will also be informed of the changes in form ESIC –54.
- (vi) Where an insured person seeks change of dispensary on a ground other than change of residence, he may apply in writing either to his existing dispensary or to the new dispensary. Two copies of the application may be prepared by the dispensary, one to be despatched to Regional Office and the other to the Administrative Medical Officer. If the Administrative Medical Officer objects to the change in allotment, he may write to the Regional Office within a fortnight of receipt of application. If the Regional Office does not hear from the Administrative Medical Officer within a fortnight, it may, if it so decides, consent to the change in allotment. In that case, the intimation should be sent by the Regional Office to the old dispensary, with copies to the new dispensary and the Administrative Medical Officer and the Branch Office concerned. On receipt of the intimation, the old dispensary will transfer the MRE of IP to the new dispensary.
- (vii) Changes will be effected in the Regional Office/designated Branch Office(maintaining ESIC-38 Register), AMO's office and in the Branch Office records (Declaration form and the ledger sheet) on receipt of intimation about change in dispensary.

Changes in age/date of birth

- 1.73. (i) When an insured person desires a change in the declared age, he may be requested to furnish one or more of the documents mentioned in Regulation 80(2). Where the desired change in the declared age is 3 years or more, the insured person should, in addition, be asked to appear before the Medical Referee who may be requested to advise whether his age and condition corroborate the revised age applied for. Such a change may then be accepted if it is applied for by the insured person before any accident resulting in permanent disablement happens to him. After an accident resulting in permanent disablement no change in age/year of birth should normally be accepted and such cases may be referred to Hqrs. with full particulars for further consideration on merits.
- (ii) However, in cases where the insured person has been served with a notice of retirement by the employer, no request for change in age may be accepted nor such insured person referred to Medical Referee for assessment of age.

Inter-regional transfer

1.74. An insured person may move from one implemented area within the region to another implemented area in the same region, or from the implemented area of one region to the implemented area of another region. Possibly, he may also join a different employer in the process. The following procedure will be followed for registration of such persons:

- (i) When such a person joins, he should be asked by his new employer to produce his old identity card alongwith 2 copies of his latest family photograph and the employer will fill up a declaration form with “Transfer Case” written in bold letters on the top and copy out all the particulars from his old identity card except the following which should be filled in as per the latest position:

(1) New employer’s code number

(2) Dispensary now opted (This column will be left blank if medical care in the area is provided through panel system)

(3) Present address

(4) Family particulars

The columns of insurance number, Branch Office will be left blank. The T. I. C. portion of the declaration form should be removed and destroyed. The employer should hand over this modified declaration form with a forwarding letter to the insured person and advise him to report alongwith his old identity card to the Branch Office to which the employer is attached. No return of declaration forms should be forwarded. The employer will also enter the name of this insured person in his register in form 7 (new form 6) and note down in pencil his old insurance number with name of his old region/area in brackets.

- (ii) When the insured person reports at the Branch Office the papers including his old identity card and a copy of his family photograph will be retained after scrutiny at the Branch Office which will then allot him an insurance number, make entries in the register of allotment of insurance numbers with the remarks “transfer case”, and issue a certificate on form ESIC-98 with family photo attached to the insured person to enable him and his family members to obtain medical treatment. This certificate will be valid for a period of 3 months from the date of issue. The insured person should be advised to report his new insurance number to his employer who will make entries in form 6 register. The Branch Manager will also make entries in a register in the following proforma:

REGISTER OF TRANSFER OF RECORDS TO THIS BRANCH OFFICE

S. No.	Date of receipt of employers letter	Name of IP	Ins. No. in old Region/B. O.	Name, address of old BO/region	New Ins. No. allotted	Date of calling records	Date of reminder(s) if any	Date of receipt of old records	Date of issue of new records	Initials of B. M.	Remarks
1	2	3	4	5	6	7	8	9	10	11	12

- (iii) If the insured person has come from an implemented area within the region, the Branch Manager of the said area should be addressed immediately to transfer his records to the new Branch Office. A copy of this letter will be endorsed to the Regional Office. In case of

centralised registration, the modified declaration form received from the employer will also be sent to the Regional Office.

- (iv) In case the insured person has come from another region and he is in a position to give the address of his old Branch Office or if, alternatively, the Manager of the new Branch Office can ascertain it from his own knowledge or records in the Branch Office, he should write direct to the Manager of old Branch Office and endorse a copy of his letter to both the old Regional Office and his own Regional Office. List of addresses of Regional Offices and Branch Offices has been printed and supplied to each Branch Office. In case, however, the address of the old Branch Office is neither known to the new Branch Office nor is easily ascertainable, the parent Regional Office of the old Branch Office should be addressed direct enclosing an additional copy of his letter for onward transmission without delay to the old Branch Office. The old Regional Office should immediately forward this letter to the old Branch Office and intimate the address of the old Branch Office to the new Branch Office to enable issue of reminders direct from the new Branch Office to the old Branch Office. A copy of the communication addressed by Manager of the new Branch Office will be duly endorsed to his own Regional Office. Both the new Branch Office and its Regional Office will send reminders to the old Branch Office/Regional Office until the records are finally received from them. All communications addressed to the old Branch Office/Regional Office should mention the full address of the new Branch Office.

Action at old Branch Office

- (v) The Manager of the old Branch Office will collect the MREs of the insured person as well as his family members from his old dispensary/IMP and send the following documents to the new Branch Offices direct under intimation to his parent Regional Office in case both old and new Branch Offices are within the same region, or to his own Regional Office under intimation to the new Regional Office if the two Branch Offices are in different regions, as the case may be.
 - (a) Attested copy of ledger sheet, if opened, should be enclosed with letter to new Branch Office. If not opened, the fact should be mentioned in the forwarding letter.
 - (b) Contributory record of the insured person for the previous 4 contribution periods beginning with the current one; provided that if no contribution has been paid by the IP in the current contribution period, the record for four immediately preceding contribution periods will be furnished. If the date of entry of the insured person falls in any of the 4 contribution periods in question, the same should be invariably indicated. If the contribution/wage record for one or more contribution periods is not available in the Branch Office, the same should be obtained from the employer and enclosed after verification of the employer's records. (This also includes the current contribution period.)
 - (c) The MRE of insured person as well as of his family members.
 - (d) An attested copy of his declaration form.

Action in old Regional Office

- (vi) On receipt of intimation from the old Branch Office about transfer of records, the Regional Office/designated Branch Office, whichever is maintaining ESIC-38 register, will make entries in ESIC-38 register and will also take exit action. If the two Branch Offices are in the same region, the Regional Office/designated Branch Office will enter new insurance number (already intimated by the new Branch Office) in the ESIC-38 register with cross-reference to entries against the old insurance number. Simultaneously, exit action at the old centre and entitlement action in the new centre will be taken under intimation to the

AMO/Dispensary/Branch Office. In case of centralised registration, the adrema plate of the insured person will be cancelled.

Action in new Regional Office

- (vii) On receipt of records in the new region, action as follows will be taken:
 - (a) If the new Branch Office is having centralised registration, the new Regional Office on receipt of intimation will prepare a new adrema plate (if adrema plates are used) on the basis of the declaration form being 'Transfer case' received earlier from the new Branch Office vide item (iii) above. It will also prepare and despatch all the records to all concerned as per procedure and practice prevailing in the region.
 - (b) However, if registration is decentralised, the new Branch Office will, on receipt of records from the old Branch Office, prepare the records as in the case of normal registration procedure and despatch the same to all concerned. It will also insert the attested copy of ledger sheet in the proper place in the proper ledger binder. The old MREs will be attached to the new MREs of the insured person as well as of the family members. The new identity card and other records will indicate the original date of entry of the insured person in insurable employment as ascertained from his old identity card. Entries in the register maintained vide item (ii) above will also be completed. The photograph earlier attached to ESIC-98 will be detached and stapled on the back of the new identity card which will be sent to the employer for delivery to the insured person. The other copy will be attached to the new declaration form.
- (viii) Before preparation of permanent documents, a comparison of the particulars as given in the attested copy of the original declaration form should be made with the new modified declaration form marked 'Transfer Case' and in case of discrepancy, the particulars given in the old form should be printed on the documents. However, in case of family particulars the latest information provided in the new form may be accepted.
- (ix) The records will then be sent to all concerned in the manner explained in para 1.40 with suitable modification in the forwarding letter to the employer.

Double registration with fraudulent intentions

1.75. A person on entering insurable employment for the first time fills in a declaration form, he is allotted an insurance number and his records are set up. At places where medical care is provided under the Service System, the insured person chooses a dispensary whereat he and his family members avail of medical benefit. In areas where medical care is provided under panel system, the insured person receives a permanent medical acceptance card which he takes to the Insurance Medical Practitioner and registers himself for medical treatment of himself and his family. For the simple fact of registration of such an insured person, an Insurance Medical Practitioner is paid a capitation fee irrespective of whether the insured person and/or his family members availed of the IMP's services in obtaining medical care.

1.76. Sometimes an insured person who has already registered himself in the manner aforesaid, leaves the service and joins another employer where he fills up a fresh declaration form without disclosing that he has already been issued an identity card. Thus, he gets himself registered a second time without being noticed and he then may also register himself with another IMP. This results in payment of capitation fee to two IMPs for the same insured person over a time period. In an extreme case an insured person may register himself at one factory/establishment and obtain an insurance number and also all permanent records and yet he may find work (in different shift) in another factory/establishment attached to a different Branch Office in the town and similarly register himself in that factory/establishment and obtain another set of records. Every Branch Manager should be on guard against all cases of double registration and he should promptly investigate any case of this nature coming to his notice and once he is able to

establish a case of double registration, he should promptly cancel one of the insurance numbers allotted to the insured person and inform all concerned through the issue of a letter in form ESIC-115 (annexure XV). Apart from the foregoing, the following further instructions are laid down for the guidance of Regional Office/Branch Office.

- (i) In cases where registration by an insured person with two Insurance Medical Practitioners results in double payment of capitation fee in the same quarter, recovery of the excess capitation fee which the Corporation and State Govt. have to pay to the Insurance Medical Practitioner, should be made from the insured person. If *mala fides* are suspected, a reference should be made to the Hqrs.
- (ii) The Regional Office will ascertain the amount of excess capitation fee from the office of the Administrative Medical Officer and will in turn intimate the Branch Office concerned who will recover the amount from the insured person. Recovery may be in cash or, if the insured person agrees in writing, may be made by deduction from cash benefit.
- (iii) The Branch Office will deal with the amount recovered from the insured person in the same way as fees for the issue of duplicate identity cards are received and accounted for.
- (iv) If, however, recovery cannot be made by the Branch Office within 6 months, intimation will be sent to the Regional Office who will take steps to recover the amount under Section 70(3) or under Section 45-C to Section 45-I of the Act.
- (v) The amount may be booked under 'Deposits-other-deposits-miscellaneous' till the amount is deposited in the treasury for credit to the Employees' State Insurance Scheme. The amount being kept in the deposit in the first instance will be paid to the Administrative Medical Officer for credit to the Employees' State Insurance Scheme so that only the net expenditure of the Administrative Medical Officer will be shared between the Corporation and State Govt. in the agreed ratio.

Prevention of double registration

1.77. With a view to prevent double registration of the insured person with two employers, the following procedure may be adopted:

- (i) If an insured person leaves service after his registration but before the receipt of temporary identification certificate or identity card, he should be given a certificate of employment by the previous employer in form ESIC-86. The date of discharge/leaving should be indicated in this certificate.
- (ii) If the insured person joins insurable employment with the new employer and produces an identity card or temporary identification certificate or the certificate of employment referred to in para (i), no fresh declaration form should be filled up and he should be treated as an old entrant and in such cases the old insurance number should continue.
- (iii) The new employer should, on completion of the first wage period by the insured person with him, ask for the permanent identity card (unless this is already with the insured person) in the following manner and deliver it to him on completion of 3 months of his service.
 - (a) From his previous employer if the date of registration was within 3 months of joining new employment.
 - (b) From the Branch Office if the date of registration was more than 3 months ago.

2.	Correspondence on funeral expenses paid	Date-wise
3.	ESIC-47 (Correspondence relating to ESB rates, relaxation of conditions of Corpn's resolution etc.)	Ins. No. wise
4.	Employment injury cases- Correspondence on	Date-wise with cross-reference to accident report register.
5.	New Form 10 (Forms 28 & 28A merged and renumbered as form 10 w.e.f.1.1.05)	Date-wise according to date of receipt of reply with cross-reference to ESIC-60 register.
6.	Correspondence on alternative evidence including complaints	Date-wise
7.	Alternative evidence cases rejected	Date-wise
8.	Correspondence (other than RM-1)	Date-wise
9.	Confinement expenses / family planning correspondence	Date-wise
10.	Live Lists	Date-wise
11.	Pending certificates	Ins. No. wise
12.	Certificates marked 'OLD'	Ins. No. wise
13.	Miscellaneous file	Date-wise
14.	ESIC-71	Contribution period wise/Date-wise with cross-reference to S. No. in ESIC-71 register
15.	PDB and DB	Separate file for each case
16.	Complaints re: non-payment of benefits	Date-wise
17.	Recovery of excess payments - correspondence on	Date-wise, with cross-reference to S. No. of entry in excess payment register
18.	Admitted employment injury cases awaiting payment	In Ins. No. order with each claims clerk.
19.	Employment injury cases awaiting investigation	Date-wise according to date of receipt of accident report, with the UDC/investigating official/Manager
20.	Correspondence on delayed declaration forms	Date-wise

- | | | |
|-----|--|--|
| 21. | Returns of contributions | Code no. wise separately for each cont. period |
| 22. | Form 1-B-renumbered as form 2 w.e.f. 1.1.05 - (Change in family particulars) -provided contents are entered in declaration form and checked and initialled by checker. Date of form 2 to be mentioned against entries in declaration form. | Date-wise separate convenient bundles stitched and kept away |

Declaration forms: weeding out:

1.81 Weeding out of declaration forms can be carried out by reference to ESIC-38 registers which are now being maintained at Regional Office(in respect of Branch Offices within the regional hqrs.) and at designated Branch Offices (in respect of outstations Branch Offices). The revised procedure for weeding out of declaration forms is given below:

(1) Declaration forms have to be retained for 20 years from the date of allotment of insurance numbers and should continue even thereafter except for those IPs in respect of whom entries have stopped appearing in the ESIC-38 register for previous 5 years and no claim for cash benefit is received during the said period. Declaration forms in respect of such insurance numbers may be weeded out.

(2) As per instructions, at the time of preparing new ESIC-38 registers, the Ins.Nos. of those IPs against whom no entries have been made in the old registers, have to be excluded. (see para 13.2.42 in this connection)

(3) A list of such insurance numbers as are being excluded from the new ESIC-38 registers, should be prepared Branch Office wise and these lists should be sent to Branch Offices maintaining declaration forms.

(4) At the Branch Office, the Ins. Nos. of those IPs whose declaration forms were allotted Ins. Nos. 20 years back should be sorted out from the list received and the existing bundles/bound volumes of declaration forms upto the last insurance number noted in the list should be ripped open and the declaration forms of such persons weeded out.

(5) The Ins. Nos of declaration forms thus weeded out should be entered in a register as per proforma given below:

Date of weeding out	Ins.Nos. of forms weeded out	Dated initials of BM.	Date of re-entry of an IP whose Form has been weedout, if any.	Dated initials of BM.
1	2	3	4	5

BM should record the following certificate on the completion of each weeding out process:

“Certified that the declaration forms of the above insurance numbers have been weeded-out under my supervision upto the period

(6) Remarks may be given in the list received from RO/designated BO against Ins. Nos. whose declaration forms have been weeded out. Declaration forms of those Ins. Nos. in the list received which cannot be weeded out because 20 years have not been completed since allotment of Ins. Nos., should be taken out

subsequently by review of this list as well as the previous ones from time to time until the new list is received.

(7) When a person whose declaration form has been weeded out, rejoins insurable employment, which fact will be noticed by the Branch Office either on receipt of return of contributions, or on receipt of a medical certificate or ESIC-37 or an intimation letter from the employer, the employer should be asked to submit a fresh declaration form on receipt of which the old insurance number may be allotted to the insured person with a cross reference and remark in the weeded out Declaration Forms Register under dated initials of the Branch Manager.

Ledger sheets: weeding out

1.82. Live Lists will be issued twice a year by the Regional Office/desingated Branch Office. On its receipt in the Branch Office, each Live List may be kept separately in a folder. Where the I.P. is not entitled to the benefit, the relevant ledger sheet should be located and the box 'Additional Information' will be bifurcated into two columns, one for 'Exit' and the other for 'Re-entry'. Entry regarding exit/re-entry will be made by affixing a rubber stamp "Exit from....." or "Re-entry from....." and the date will be filled in hand or by means of a date-stamp. Special rubber stamp may be got prepared for the purpose. After entry the ledgers alongwith lists will be passed on to the checker who, after check, should put his dated initials on each entry. 10% of the entries should be checked by the Head Clerk also and in offices where there is no Head Clerk, by the Manager himself. A certificate will thereafter be sent to the Regional Office to the effect that action regarding entry of exit/re-entry has been completed.

1.82 A. Once in every 6 months, at the end of June and December each year, all ledger sheets should be reviewed and those ledger sheets which have remained 'Exit' for three consecutive benefit periods and which have been audited by external auditors should be removed and kept separately under safe custody of the Branch Manager. An indication of 'exit' by the letter 'X' may be given in respect of such removed cases against the insurance number in the index sheet. As and when an insured person becomes re-entitled, the ledger sheet will be re-inserted at the proper place in the ledger and appropriate indication given in the index sheet by the letter 'R'. A fly-leaf may be kept in each ledger and every time a ledger is reviewed in the manner stated above, an indication may be given under dated initials of the Branch Manager.

1.82 B. Ledger sheet in which no benefit amount has been paid during the last 5 years (except where audit objections exist) and the IP is not entitled to medical benefit, may be weeded out. Ledger sheets of IPs who are known to have left service prior to 5 years or died may also be weeded out provided there is no audit objection pending. An entry may also be made in the index sheet about ledger sheet weeded out under Manager's dated initials.

Medical record envelopes: weeding out

1.83 (i) The medical record envelope [MRE] of self and family of an insured person who is no longer entitled to medical benefit is to be retained in the dispensary for a period of 5 years after the date of exit. If his ins.no. does not find mention in any of the Live Lists received in the meantime, the IMO should return all such MREs to concerned Branch Office who may re-use them after pasting slips on them.

(ii) The medical record envelope of an insured person who has died, should be returned by the IMO to the concerned Branch Office. At the concerned Branch Office, the medical record envelopes of those persons who died of employment injury will be retained for a period of 5 years and those of others should be retained for a period of 3 years after the date of death. After the period herein specified, these envelopes should be weeded out and destroyed.

Temporary residents

1.84. An insured person wishing to go to another place on leave or on duty, should be advised to obtain a certificate of employment from his employer in form ESIC-105. This certificate will enable him to

obtain medical treatment and certificates (if need be) from the IMO/IMP of the area visited by him, for a period of three months from the date of issue. The IMO/IMP will retain ESIC-105 with him and issue to the insured person an out-patients slip which the latter should preserve carefully to enable him to obtain treatment and certificate on the strength of this slip. If his family accompanies him to outstation, the family members will also be entitled to medical treatment on the strength of ESIC-105 on production of photo identity card, for a period of 3 months from the date of issue of ESIC-105 by the employer.

Persons erroneously registered

1.85. The case of a person who has been erroneously covered under the *bona fide* belief that he was an 'employee' as defined in the ESI Act, as and when it arises, has to be referred to Headquarters for admittance by the Director General who has been empowered by a resolution of the Corporation passed at its meeting held on 2nd December, 1963. While referring such cases, full justification and circumstances in which the person was erroneously registered and later found not coverable, may be furnished by the Branch Manager to the Regional Office which will forward the case to Hqrs. Office.

Duplicate identity cards

1.86. Regulation 18 of the ESI (General) Regulations, 1950 states that in case of loss, defacement or destruction of an identity card, the IP shall report the matter to the appropriate Branch Office, and the Corporation may issue a duplicate copy of the identity card subject to such conditions and payment of such fee as may be determined by Director General.

1.87 (i) Specimen of form 4 – identity card – at present in use for IP and his family appears in the ESI (General) Regulations. This card also contains photograph of IP and his family members. This card will be placed in plastic cover and its life will be 5 years whereafter it may be replaced free of cost.

(ii) Where family resides elsewhere in the same state or in a different state, form 4A is used for the family identity card and its specimen can also be seen in the ESI (General) Regulations. Likewise, this card will also be in plastic cover and its life will be 5 years whereafter it may be replaced free of cost.

1.88. The instructions regarding replacement of old cards by duplicate identity cards, and issue of duplicate identity cards to replace lost ones, are summarised as under: -

At the Branch Office

- (1) Two separate bundles of DICs (a) for issue against payment of fee and (b) to be issued free in replacement of an old and dilapidated card after being rubber stamped 'DUPLICATE' will be sent by the Regional Office to each Branch Office in suitable numbers. These cards will be machine-numbered at the Regional Office and entered in a register before despatch to the Branch Office. On receipt of each bundle, the Branch Office will count them and enter them separately alongwith respective serial nos, in the register of issue of duplicate identity cards by means of separate and distinct entries duly attested by the BM.
- (2) Applications for issue of DICs will be received in the Branch Office in form ESIC-72. Every such application must be accompanied by the photograph of IP and/or his family as the case may be. Where two separate DICs are required, one for IP (form 4) and another for the family residing away from the IP (form 4A), fee will be charged on both. Separate form ESIC-72 will also be submitted by the IP. Each form should be attested by any one of the following:-
 - (i) The employer of the IP,
 - (ii) His previous employer,
 - (iii) The president or secretary of a trade union or

- (iv) A person known to the Branch Office.

Application form not attested by any of those mentioned above or received without photograph should not be entertained. Herein, the employer means either the principal employer himself or any senior or authorised officer and not a clerk or a so called consultant, etc. In this connection, please also see paras 1.89 to 1.90 below.

- (3) Where the insured person is no longer in employment, application for issue of DIC should be attested by the secretary/president of the trade union or by his previous employer or by any other person known to the Branch Office. However, in such cases the BO should ensure before issue of DIC that IP or a member of his family is entitled to any of the benefits under the Act, including PDB or medical benefit.
- (4) Fee for replacement of a defaced card within 5 years of its date of issue and for issue of a duplicate card against one that has been reported lost, will be one rupee in respect of each application for which a receipt shall be issued by the Branch Office under Manager's signature in Form-1 prescribed under Rule 21 of ESI (Central) Rules, 1950.
- (5) In the following cases, no fee will be charged:-
- (i) When the old card (with plastic cover) issued five years earlier than the date of application is produced for replacement.
 - (ii) The IP was issued separate identity cards, one for himself and another one for his family and he produces at least one for replacement.
 - (iii) The IP had gone out of coverage earlier due to a raise in his wages, but was covered again due to an increase notified in the wage limit for coverage, and having lost his original card, approaches the BO for issue of an identity card to enable him to avail of benefits under the Act.

(6) Procedure for replacement of old card and lost card

(i) Every applicant for a DIC will be directed to see the registration clerk who will satisfy himself about the applicant's identity from his photograph, the ledger sheet or declaration form, if available in the Branch Office. He will also check particulars of the old card if produced for replacement and the particulars given in the application, its attestation, etc. In case fee is to be charged, he will collect the same from the insured person and enter the particulars in the printed receipt as well as its counterfoil. He will then prepare the required duplicate identity card from adrema impression or written particulars available in the ledger sheet. If ledger sheet has not already been opened, he will also prepare the ledger sheet. He will enter the words "Duplicate identity card for self and/or for family (say which one) issued on" in the middle column of ledger sheet under the heading "Additional Information". If a DIC has already been issued earlier and the present application is for one of the same type, the IP should be questioned closely about the earlier DIC. His signature/thumb impression on the application should be compared with that on the declaration form to rule out any possibility of impersonation. His identity should be checked from his family photograph if that is available on the declaration form. The claims clerk will also get the family photograph stapled on the back of the DIC. He will also enter the particulars in the register of issue of DICs whereafter he will pass on all the connected papers to the checker. After a check by the checker, the papers will be sent to the Manager for his signature. The Manager will sign the printed receipt (if fee is charged), the duplicate identity card, the entry in the ledger sheet, and also put his dated initials in the counterfoil of the receipt book and the entry in the register of DICs. If DIC is issued in replacement of old card, the old card will be retained by the Manager in his custody. He will call in the insured person, ask him to sign on the DIC and also in the register of DICs in his presence and after satisfying himself with the identity of the

insured person, hand over the card to him. He will also retain the old card in his custody if DIC is issued free of cost.

(ii) If IP was earlier issued separate identity cards, i.e., one for himself alone and another for his family residing in a different town in the same or other state, the type of DIC required by him will be issued and the markings mentioned in the para 1.70A will be recorded in capital letters in the card being issued. The clerk will mark the type of card, viz., form 4 or form 4A, being issued as the case may be.

(7) The register of DICs will be maintained in the following proforma: -

S. No.	Date of entry	Date of application	Name of the IP	Ins. No.	Amt. of fee received	Receipt No. & date	Sl. No. of card issued	Date of delivery of card	Date of sending intimation to IMO/IMP	Initials of Manager	Sig. of the insured person	Remarks, if any
1	2	3	4	5	6	7	8	9	10	11	12	13

At the end of each month, a summary of DICs received and issued will be drawn up in the register with the following columns:

SUMMARY OF DICs RECEIVED AND ISSUED DURING

	Priced cards			Free Cards		
	From S. No.	To S. No.	Total	From S. No.	To S. No.	Total
Opening Balance						
Received during month						
Grand Total						
Issued:						
at Branch Office						
at Pay Office						
Stock transferred to other Branch Office(s)						
spoilt cards						
Total						
Balance in hand						
Closing stocks as above physically verified and found correct						

Manager

(8) Whenever a duplicate identity card is issued to an insured person, an intimation to this effect should be sent to the Insurance Medical Officer / Insurance Medical Practitioner concerned and on receipt of this intimation entry will be made by the IMO/IMP on the MRE of the

insured person, “Duplicate Identity card No..... issued on”.
The proforma of the standard letter to be issued is given below:

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No.

To

The I.M.O.,
ESI Dispensary,
.....

To

Dr.....,
Insurance Medical Practitioner,
.....

Sub: Issue of duplicate identity card to Shri
Insurance No.

Sir,

I have to inform you that a duplicate identity card No. has been issued to the IP referred to above on

You are, therefore, requested to record a remark to this effect by a rubber stamp on the relevant records of the IP/ his family maintained with you so as to ensure that the IP makes use of only one identity card. In case the original identity card is produced after the issue of duplicate identity card, the same may be impounded and the IP/family suitably interrogated to prevent against impersonation.

The identification marks of the insured person on his MRE as well as of his family members on the family MRE may also please be entered in the space provided in the DIC under your signature.

Yours faithfully,

MANAGER

Cyclostyled or printed copies of this letter may be requisitioned from the Regional Office by each Branch Office and the letter be issued simultaneously with the issue of the duplicate identity card.

(9) The amounts received by the BM for the issue of duplicate identity cards should be entered in the Branch Office cash book A/c No. 1 and deposited into the bank in Account No. 1 on the last working day of each month, or earlier if such amount reaches the limit of Rs. 1000/- for credit to the head 'VII-Miscellaneous-Price of Duplicate Identity Cards'.

(10) Sometimes it may happen that the Branch Office does not have a ready stock of DICs and replacements are awaited from the R. O. In such cases, if the application is for a lost card, the BM should endorse on top of the receipt issued for the D. I. C., 'Valid for treatment for one month' and, if necessary, add particulars etc., of his family members as given in the declaration form, on its back, attach photograph of the I.P and of his family and attest entries on both front and back sides of the receipt. This will enable the IP and his family members to obtain medical treatment. As for applications for replacement of old card, the IMO may be suitably requested by an endorsement on the application itself or otherwise to entertain the same for the time being until fresh supplies of DICs are received. In the meantime, no effort should be spared to obtain the stock of DICs from the R. O.

(11) In the cases aforesaid, where fee has been accepted but a DIC is prepared later, it may sometimes happen that some IPs do not turn up to collect their DICs. Such a DIC should remain in the custody of the BM. If the IP does not turn up to receive his DIC for a period of 3 months from the date of its preparation, a reminder asking him to take the delivery should be issued. All DICs remaining unclaimed should be destroyed at any time after a lapse of one year from the date of their preparation under the supervision of an officer of the R. O. on his

visit to the Branch Office. The Branch Office will keep a record of unclaimed DICs and of their disposal and destruction.

(12) After a DIC has been issued to an insured person, if he produces his original card or after a second DIC has been issued and he produces either the original identity card or his DIC issued earlier, no payments should be allowed in either case and the insured person should surrender the same at the Branch Office where it should be cancelled. The fact whether a duplicate card has been issued or not can be easily known from the ledger sheet.

(13) Every DIC should be prepared with utmost care to avoid any spoilage. However, in case any DIC is spoiled while under preparation, it should be also entered in the register of DICs with the remarks 'spoiled'. These remarks should be attested by the Manager who should keep the spoiled card in safe custody and for production to audit party during the next visit. Thereafter, these cards should be destroyed in the presence of a visiting officer of the R. O. who may record a certificate "Spoilt identity cards with S. Nos and destroyed in my presence" over his dated signatures.

(14) The Cashier of parent Branch Office, during his visit to the Pay Office will accept fee alongwith application for a duplicate identity card duly accompanied by his family photograph and issue the provisional receipt with the remarks on the top "Valid for medical treatment for one month". However, on return to the parent Branch Office, he will enter the amounts received on receipts side of the parent Branch Office cash book account No. 1. He will then prepare a regular receipt for each amount of fee, and add the words 'This cancels the provisional receipt No.....dt.....' and "Not valid for medical treatment" on the top of each such receipt. The Branch Manager will sign the regular receipts and attest entries in the cash book. The Manager will get the duplicate identity cards prepared immediately and these will be taken by the Cashier to the Pay Office during his next visit and delivered to the concerned IPs after taking signatures/thumb impression on the DIC as well as in the register meant for the purpose. He will also hand over letter specified in sub-para (8) to the IMO.

(15) The following register will be maintained for the pay office:-

PAY OFFICE.....

ISSUE REGISTER OF DUPLICATE IDENTITY CARDS							
S. No.	S. No. of BO register of DICs.	Name of IP	Ins. No.	Date of issue of DIC	Date of issue of intimation to IMO/IMP	Signature of I. P.	Remarks
1	2	3	4	5	6	7	8

(16) It should be noted that instructions regarding scrutiny of applications, acceptance of fee, issue of DIC free of cost in replacement of old cards, DIC for a lost/misplaced identity card /DIC issued earlier, destruction of DIC, intimation to IMO/IMP etc., as described in paragraphs detailing the procedure for DICs at the Branch Office will also apply with suitable modifications, where necessary, in respect of pay office.

(17) The procedure for issue of a duplicate identity card to a permanently disabled or a retired person vide Chapter XIII A will be the same as declared above, subject to such modification as may be required.

(18) The procedure for issue of DIC to an employee of an OD prone industry (see para 1.68) who was earlier issued a red card, will be the same as above, with the distinction that such a DIC will also be of red colour and should be supplied and replenished by the Regional Office.

Special steps against fraudulent use of identity cards

1.89. The correct procedure as laid down in the preceding paragraphs regarding issue of identity cards/duplicate identity cards, if followed carefully and scrupulously, can prevent, to a very great extent, the misuse of this Scheme both at the dispensary and at the Branch Office. Instances of fraudulent use of identity card/DIC coming to notice have necessitated the adoption of more stringent measures as listed below which are to be read as a supplement to those laid down in para 1.88 and which must be strictly followed by all concerned:

- i) The Branch Office shall arrange to have an identity card prepared in Form-4 and 4A where necessary for each person in respect of whom an insurance number is allotted and shall send all such cards to the employer. The employer shall, if and when the employee has been in his service for three months, obtain the signature or thumb impression of the employee on the identity card and shall, after making relevant entries thereon, deliver the identity card to him. The employer shall also obtain a receipt from the employee for the identity card. The identity card in respect of an employee who has left employment before 3 months shall not be given to him but shall be returned to the Branch Office as soon as possible. The identity card shall not be transferable.
- ii) The employer will not indicate the identification mark of the insured person as well as each family member on the identity card. The identification mark will be recorded by the IMO/IMP on the identity card of the IP/family at the time of the IP's or the family member's first visit to IMO/IMP and also in the case of duplicate identity card, if issued, when he/she visits the dispensary after issue of the duplicate identity card to him/to the family.
- iii) If an IP applies for issue of DIC in case of loss, defacement or destruction of his original identity card, his application on form ESIC-72 should be attested by the principal employer or other authorised signatory but not by any clerk etc.
- iv) At the time of issue of duplicate identity card, an entry to this effect must be made by the Branch Office in the ledger sheet of the insured person under the signature of Branch Manager.
- v) The duplicate identity card can be misused by the persons who are not entitled to receive medical benefit. To check this and to enable the IMO/IMP to detect impersonation, it is imperative for the Branch Office to inform the IMO/IMP about the issue of the DIC and for this, the letter as per specimen given in paragraph 1.88(8) above should be invariably issued to the IMO/IMP who should enter the remarks "Duplicate Identity Card No..... issued on" by means of rubber stamp on the MRE of the IP/family under his signatures. The IMO will also record the identification marks of this IP on his identity card as provided in sub-para (ii) above. IMO's remark on the MRE will enable seizure of any other card (original identity card or duplicate one) issued prior to the date indicated on the MRE.
- vi) When the insured person visits the Branch Office first time for payment, an entry regarding identification mark recorded in the identity card by the IMO/IMP be made under the signature of the Branch Manager in the relevant space already provided in the ledger sheet. If a column does not exist in the form in use in any Branch Office, the same may be specifically opened and entry made therein.
- vii) In cases where duplicate identity card has been issued to insured person, no cash benefit payment should be made by the Branch Office based on the identity card/duplicate identity card issued earlier. The fact about issuance of original/duplicate identity card issued earlier can be known from the ledger sheet.
- viii) If any impersonator is found to have approached the Branch Office to receive cash benefit payment based on the original identity card/duplicate identity card issued earlier, the same

may be reported to the nearest police station and FIR lodged under intimation to the Regional Director.

Employer's communications must be authenticated

1.90. It has been observed that various forms and returns to be submitted to the Branch Office and Regional Office, e. g., declaration form, RDF, ESIC-86, form-1A, form-2, form-01, ESIC-37, RC etc., all of which form the basis for provision of benefits under the ESI Scheme are generally signed and submitted to the Corporation with the signatures of some officials of the factory whose identity is difficult to make out or by someone on behalf of authorised persons without mentioning the name and designation of the person signing. It is, therefore, to be ensured that communications sent by the employer bear the signatures, name and designation and rubber stamp of an authorised signatory e. g., factory/personnel manager, welfare officer, etc. For this, Branch Office should obtain details, e. g., name and designation of principal employer as well as authorised officials from all the employers of factories/estts. attached to the Branch Office and keep them on record. The Branch Manager should accept communications signed by one or other of these officials only. This record should be updated from time to time.

(b) REGISTRATION OF DISABLED PERSONS

Welfare of Disabled Persons

1.91 With a view of creating jobs in the Private Sector for disabled persons, the Central Government announced a Scheme in which it would bear the employer's contribution payable under the EPF Act 1952 as well as under the ESI Act, 1948, in respect of disabled persons in receipt of wages upto Rs 25000/- pm. In pursuance of this decision, Central Government inserted new Rule 51A and amended Rules 50 and 54 of the ESI (Central) Rules, 1950. These provisions came into force from 1st April, 2008.

Wage Limit for coverage

1.92 Under the above amendments, wage limit for coverage of a disabled employee under 'The Persons with Disabilities (Equal Opportunities Protection of rights and Full Participation) Act, 1995 (1 of 1996), and under the National Trust of Welfare of Persons with Autism, Cerebral palsy, Mental Retardation and Multiple Disabilities Act 1999 (44 of 1999), shall be Rupees twenty-five thousand a month.'

Submission of Declaration Forms

1.93 Every employer who provides employment to a person with disability as per details provided in Annexure XVI should submit declaration form of every such person with distinct marking 'DISABLED' along with copy of disability certificate issued by the competent authority (proforma at Annexure XVII) with the appropriate Branch Office within 10 days of his appointment as required under Regulation 14. On receipt of such a declaration form, the Branch Office shall allot an Insurance number with distinct marking 'D' (as suffix) and issue TIC for availing benefits under the ESI Scheme.

Progress report on registration

1.94 A monthly statement indicating the number of such disabled employees registered with the Branch Office should be forwarded to the Regional Office by 7th of the next month. The Regional Office will forward a consolidated statement for the whole Region to the Benefit Division of Hqrs. Office, with a copy of it endorsed to Revenue Division, by 15th of following month.

Submission of RC for Disabled Persons

1.95 The employer has to furnish the details of wages and contributions in respect of disabled employees in a separate sheet along with the RC for each contribution period ending 31st march and 30th September. In the column against employer's share of contribution in respect of such employees, employer can write "To be paid by the Government".

Entries in ESIC-38 Register

1.96 While posting returns in ESIC-38 register in respect of such disabled person(s), the Regional/Branch Office shall also maintain a separate record in respect of these disabled persons along with the details of contributions due but not paid by the employer. A statement shall be sent to Hqrs. Office Revenue Division for making good the employer's share of contribution in respect of such disabled Insured Persons from the corpus to be provided by the Central Government within 30 days of the receipt of such a statement.

ANNEXURE-I

(See Paragraphs 1.10 & 1.55)

BRANCH OFFICE.....
EMPLOYEES STATE INSURANCE CORPORATION

BLANK FORMS STOCK REGISTER

NAME OF FORM.....

FORM NO.....

RECEIPT				ISSUE								
Date of receipt	Challan		Number received	Date of issue	Challan		To whom issued	No. of forms issued	Balance	Initials of record keeper	Initials of BM	Remarks
	No.	Date			No.	Date						

ESIC-120

ANNEXURE II
(See paragraph 1.10 & 1.55)

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

CHALLAN FOR BLANK FORMS

The undermentioned forms are sent herewith. Please return the duplicate copy of this challan duly received by you.

S. No.	Particulars	Quantity	Remarks

MANAGER

TO

M/s. _____

Certified that the above forms have been received in order

SIGNATURE _____

DESIGNATION _____

ADDRESS _____

DATE _____

CODE NO. _____

LETTER NO. 1

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Date: _____

To

Sub.: Late submission of declaration forms.

Dear Sir/s,

Kindly refer to the declaration forms sent by you in respect of your employees under instalment No. _____ dated _____. It is observed that forms in respect of some/all of the employees have been sent much after the time-limit laid down in Regulation 14 read with Regulation 11/12 of the Employees' State Insurance (General) Regulations, 1950, according to which the declaration forms are required to be sent to the Branch Office on or before the 10th day following the date on which the persons concerned are taken into employment. Delays in submission of declaration forms upset the whole timetable for printing and distribution of various documents including the identity card, the medical record envelope etc., and it causes unnecessary inconvenience to the insured persons and their families. I have, therefore, to request you to ensure that the declaration forms in respect of the persons taken into employment by you from time to time are sent to this office within the time-limit laid down in Regulation 14 referred to above. I need hardly add that failure to do so will amount to contravention of the provisions of the Act and Regulations for the purpose of Section 85.

Yours faithfully,

MANAGER

LETTER No. 2

UNDER CERTIFICATE OF POSTING

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Dated _____

To

Shri _____
Managing Director/Manager,

Sub: Late submission of declaration forms.

Dear Sir/s,

Please refer to the declaration forms sent by you in respect of your employees under Instalment No. _____ dated _____. I regret to say that in spite of the requests of this office for timely submission of the declaration forms, these are still being submitted to this office much after the time limit laid down in Regulation 14 of the E. S. I. (General) Regulations, 1950.

In this connection, I have to invite your attention to this office letters of even No. dated _____ and _____ under which the delay in submission of declaration forms had been brought to your notice. This office will be left with no alternative but to resort to the unpleasant duty of recommending legal action against you under Section 85 of the E. S. I. Act in case such delays continue hereafter. I hope you will kindly spare this office from taking the action by ensuring timely submission of the declaration forms.

Yours faithfully,

MANAGER

LETTER No. 3
UNDER CERTIFICATE OF POSTING

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Dated _____

To

Sub: Late submission of declaration forms

Dear Sir/s,

It is very much regretted that in spite of repeated requests from this office *vide* letters No. _____ Dated _____ you have not so far submitted declaration forms at all/failed to submit declaration forms within the time limit prescribed under Regulation 14 read with Regulation 11/12 of the E. S. I. (General) Regulations, 1950 according to which these forms are required to be sent to this office on or before the 10th day following the date on which the persons concerned are taken into employment.

A few instances of late submission of declaration forms are given below:-

S. No.	Ins. No. of the IP	Date of entry	Date of submission of the declaration form	Remarks
--------	--------------------	---------------	--	---------

- 1.
- 2.
- 3.
- 4.
- 5.

It may please be noted that if this breach is committed in future, I shall recommend your prosecution under Section 85 of the Act to the Regional Office.

I hope you will pay heed to my request in your own interest and ensure timely compliance in this respect.

Yours faithfully,

MANAGER

LETTER No. 4

REGIONAL OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Dated _____

Show Cause Notice

From

The Regional Director,

To

Sub: Submission of declaration forms as required under Regulation 14 of the ESI (General) Regulations, 1950.

Dear Sir/s,

It has been reported by the Manager, Branch Officethat in spite of his repeated requests vide his letters No.....dated.....you have failed to comply with the provisions of Regulation 14 of the Employees' State Insurance (General) Regulations, 1950 regarding the submission of declaration forms in respect of all of your/the following employees: -

S. No.	Ins. No. of the IP	Date of entry	Date of submission of the declaration form	Remarks
--------	--------------------	---------------	--	---------

- 1.
- 2.
- 3.
- 4.
- 5.

Failure to comply with the provisions of the Employees' State Insurance Act and Regulations made thereunder is an offence punishable under Section 85 thereof. I am, therefore, to call upon you to show cause within 10 days from the date of this letter why you, as one of the principal employers of the factory/establishment should not be prosecuted for committing breach of Regulation 14 of the Employees' State Insurance (General) Regulations in not sending the declaration forms in respect of your/the above employees within the time limit prescribed thereunder.

Yours faithfully,

For REGIONAL DIRECTOR

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Dated: _____

To

Sub.: Correction of declaration forms found defective.

Dear Sir/s,

Please refer to the return of declaration forms submitted by you under your letter No.....dated..... I enclose herewith the declaration forms listed below, which have been found defective, for your correction. In column 4 of this list nature of the defect has been indicated with reference to the list of standard defects endorsed overleaf. This list also includes declaration forms which, though mentioned on the R. D. F. have been found missing. Kindly return the defective forms duly corrected as well as those shown in this list as missing, alongwith a separate return of declaration forms in duplicate:

S. No.	Name of employee	Serial no. on return of declaration forms	Reference to the defects detailed overleaf
1	2	3	4

Yours faithfully,

MANAGER

Enclosures:

LIST OF DEFECTS REFERRED TO ON REVERSE.

1. The name of employee is not legible. Please re-write legibly in block letters.
2. Surname has not been indicated.
3. Sex has not been indicated.
4. Marital status has not been indicated
5. Father's or husband's name is not indicated
6. Father's or husband's name is not legible.
7. Age/Date of birth has not been indicated.
8. Age is not legible. Please re-write clearly.
9. There seems to be a discrepancy about the year of birth, please verify and give the correct date and year of birth.
10. Present residential address is not given in full.
11. Present residential address is not written legibly.
12. Permanent home address is not given in full.
13. Permanent home address is not written legibly.
14. Choice of dispensary is not given.
15. Name of nominee under Section 71/Rule 56(2) of the ESI (Central) Rules, 1950 has not been given.
16. The name, address and father's/husband's name of nominee has not been given correctly.
17. The form has not been signed by the employee.
18. The form has not been countersigned by the employer.
19. The form has to be re-written clearly and submitted afresh.
20. Department of factory is not indicated.
21. The actual date of entry into insurable employment has been left blank.
22. Photograph is not attached/defective/is antiquated.

BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

Index Sheet

Month		Branch Office					
S. No.	Name of the insured person	Father's name	Ins. No.	Code No. of employer	Date of entry	Name of dispy. opted	Remarks
1	2	3	4	5	6	7	8

EMPLOYEES' STATE INSURANCE CORPORATION

Medical Record – Family Members

Ins. No.		Employer's code No.	
Name of IP		Year of birth	
Branch Office		Date of entry	
Present address		Dispensary/IMP	
		Identification mark	

Name of the family member	Relationship with the IP	Date of birth	Identification Mark	Remarks/date and cause of exit/death
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

The Doctor should see that the particulars on the front are properly filled in

Date	*	Clinical notes	Diagnosis	Group no.

*This column has been provided for Doctors to enter A, N or C at the their discretion

This record is the property of ESI Corporation

BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____

Dated: _____

To

M/s. _____

Dear Sirs,

I am forwarding herewith identity cards and permanent acceptance cards in respect of the following insurance numbers with the request that these may please be distributed only to those employees who have rendered 3 months' service and, where there is a break in service, to those employees who have put in 3 months' service in aggregate excluding the periods of break in service. Before handing over the Identity Cards, signature/thumb impression of the insured person may invariably be obtained in the space provided for the purpose on the card.

Insurance Number		Net no. of identity cards	Remarks
From	To	and permanent	
		acceptance cards	

I have also to request you to return immediately the identity cards and permanent acceptance cards in respect of all those persons who have left your service before the expiry of 3 months' service in aggregate from the date of appointment.

Yours faithfully,

MANAGER

- Note:
1. In case of service system, the words permanent acceptance cards should be scored out.
 2. This form will be used in case of new entrants only.

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

To
The Administrative Medical Officer,
Insurance Medical Officer,
ESI Dispensary.

Sir,

The following documents are sent herewith. Please return the duplicate copy of the challan duly received.

Nature of document	Nos. (With Ins. Nos.)	Remarks
--------------------	--------------------------	---------

MANAGER

Certified that the above documents have been received in order/and the following discrepancies have been noticed:

Date: _____
Signature _____
Designation _____
Stamp _____

(To be printed on yellow paper in black ink on the specifications of paper and size as of present T. I. C. attached to declaration forms)

ONLY FOR FAMILY MEMBERS NOT RESIDING WITH INSURED PERSON

**EMPLOYEES' STATE INSURANCE CORPORATION
TEMPORARY IDENTIFICATION CERTIFICATE
(Valid for 3 months from the date of appointment)**

Insurance No. _____

Name of insured person _____
Dispensary _____

Particulars of members of family:				
Serial No.	Name	Date of birth	Relationship with insured person	Whether residing with him/her or not

Name, address and Code No. of the employer _____
Branch Office _____
Dispensary for family _____
Date of appointment _____

**SIGNATURE OR THUMB IMPRESSION OF
THE INSURED PERSON**

RECEIPT OF THE FAMILY IDENTITY CARD.

Received the family identity card bearing Insurance No.....

SIGNATURE OR THUMB IMPRESSION OF INSURED PERSON

OPTION FORM FOR REGISTERING MEMBERS OF THE FAMILY FOR AVAILING
MEDICAL BENEFIT FROM ESI DISPENSARY/IMP SITUATED IN OTHER STATE

I _____ (Name of the IP) S/.W/D/O _____ Ins. No. _____ resident of _____ hereby declare that the following members of my family are residing at _____ in _____ State.

They may be allowed to avail medical care from nearby ESI Dispensary/IMP at _____ (complete address) till further notice. The address of the Branch Office in whose jurisdiction the above said residence falls is _____.

I understand that once above option is made, these family members shall receive medical care only from above ESI Dispensary/IMP till the option is changed subject to entitlement.

PARTICULARS OF FAMILY MEMBERS				
SL. NO.	NAME	DATE OF BIRTH	RELATIONSHIP	REMARKS, IF ANY
1				
2				
3				
4				
5				

Two copies of my family photographs are enclosed.

Date: _____ Signature _____

Place:

Countersigned (By employer)

(_____)

M/s _____

BRANCH OFFICE
ESI CORPORATION

No.

Dated:

To

The IMO
ESI Dispensary

The IMP

Subject :- Registration of IPs/Family members who reside in other states for availing medical benefit.

Sir,

The following IPs have informed that their families are residing at (complete address) _____ in (State) _____, which falls under your jurisdiction. You are requested to register them with your Dispensary and provide them necessary medical benefit if otherwise entitled. MRCs in these cases may be prepared as and when the family member reports for taking treatment. Entitlement status may please be checked in each benefit period.

Sl. No.	Name of the IP	Ins. No.	Name of the family members	Date of Birth	Relationship	remarks
1	2	3	4	5	6	7

Yours faithfully,

MANAGER

Copy for information and necessary action to:

- 1) Branch Office in opted State _____
- 2) Regional Office, ESI Corporation _____
(Region of opted ESI Dispensary/IMP)
- 3) Regional Office, ESI Corporation _____
(Region of the Branch Office sending above letter)

BRANCH OFFICE
ESI CORPORATION

(To be sent before commencement of benefit period)

No.

Dated:

To

The IMO
ESI Dispensary

Dr. _____
I.M.P., ESI Scheme

Subject :- Entitlement for Medical Benefit under the ESI scheme – Live lists for the benefit period.

Sir,

The families of the following IPs who have opted for medical benefit for their families through your dispensary/clinic, are entitled to medical benefit for the period commencing from _____ to _____. It is requested that medical benefit may be made available to their family members w.e.f. aforesaid date unless otherwise notified.

Name	Ins. No.	Name	Ins. No.

MRE/MRC, if not prepared already may be prepared and kept in regular run.

Yours faithfully,

MANAGER

Copy for information and necessary action to:

- 1) Branch Office in opted State _____
- 2) Regional Office, ESI Corporation _____
(Region of opted ESI Dispensary/IMP)
- 3) Regional Office, ESI Corporation _____
(Region of the Branch Office sending above letter)

BRANCH OFFICE.....
EMPBOYEES' STATE INSURANCE CORPORATION

No. _____

Dated: _____

To

M/s. _____

Ref.: Shri _____

Ins. No. _____

Dear Sirs,

With reference to your letter no.....dated..... I have to inform you that the above mentioned insured person has been allotted Ins. No.....earlier/late, while he was in employment of M/s..... He should have brought this fact to your notice at the time of taking employment with you and a fresh declaration form should not have been filled up in respect of him. The insured person may kindly be warned to be careful in future in regard to double registration.

You may continue to use the Ins. No..... for all purposes in future. Contributions if any, paid on cancelled Ins. No. are being adjusted on the retained Ins. No..... In case the insured person is in possession of the identity card of cancelled insurance number, the same may please be collected from him and returned to this office for cancellation.

Yours faithfully,

MANAGER

Copy to:

1. Regional Office for information and –
 - (i) intimation to AMO for ascertaining the amount of capitation fee paid/payable and intimating the same to this office so that the same could be recovered from this insured person, and cancelling index card with Ins. No.....
 - (ii) cancellation of Ins. No..... from ESIC-38 register maintained at Regional Office.
2. The Manager, Branch Office, with a request to please transfer ledger sheet of the Ins. No.....to this office so that the amount of double payment, if any received by this I. P. may be recovered from him.

Definition of Disabilities as per the Persons with Disabilities (Equal Opportunities, protection of Rights And Full Participation) Act, 1995

1. “Disability” means-
 - (i) blindness;
 - (ii) low vision;
 - (iii) leprosy-cured;
 - (iv) hearing impairment;
 - (v) loco motor disability;
 - (vi) mental retardation;
 - (vii) mental illness;
2. “Person with Disability” means a person suffering from not less than forty per cent of any disability as certified by a medical authority.
3. “Blindness” refers to a condition where a person suffers from any of the following conditions, namely:-
 - (i) total absence of sight; or
 - (ii) visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses; or
 - (iii) limitation of the field of vision subtending an angle of 20 degree or worse;
4. “Person with Low Vision” means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device;
5. “Leprosy Cured Person” means any person who has been cured of leprosy but is suffering from-
 - (i) loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;
 - (ii) manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity;
 - (iii) Extreme physical deformity as well as advanced age which prevent him from undertaking any gainful occupation,and the expression “leprosy cured” shall be construed accordingly;
6. “Hearing Impairment” means loss of sixty decibels or more in the better ear in the conversational range of frequencies;
7. “Loco motor Disability” means disability of the bones, joints or muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy;
8. “Cerebral Palsy” means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, peri-natal or infant period of development;
9. “Mental Retardation” means a condition of arrested or incomplete development of mind of a person which is specially characterized by sub normality of intelligence;
10. “Mental Illness” means any mental disorder other than mental retardation;

Definition of disabilities as per National Trust for the Welfare of Persons With Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999

1. “Person with Disability” means a person suffering from any of the conditions relating to autism, Cerebral Palsy, Mental Retardation or a combination of any two or more of such conditions and includes a person suffering from severe multiple disability;

2. "Autism" means a condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behaviour ;
3. "Cerebral Palsy" means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the prenatal, perinatal or infant period of development;
4. "Mental Retardation" means a condition of arrested or incomplete development of mind of person, which is specially characterized by sub-normality of intelligence;
5. "Multiple Disabilities" means a combination of two or more disabilities as defined in clause (i) of section 2 of the Person with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995;
6. "Severe Disability" means disability with eighty per cent or more of one or more of Multiple Disabilities;

STANDARD FORMAT OF THE DISABILITY CERTIFICATES AS PRESCRIBED IN THE
GUIDELINES FOR EVALUATION OF VARIOUS DISABILITIES AND PROCEDURE FOR
CERTIFICATION-NOTIFIED VIDE GAZETTE NOTIFICATION NO.16-18/97-NI-I.
DATED 1ST. JUNE, 2001

NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE

Certificate No.
Date

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

This is to certify that Shri/Smt./Kum/Wife/Daughter of Shri _____
Age _____ old male/female, Registration No. _____ is a case of physically
disabled/visual disabled/speech & hearing disabled and has _____ % (_____)
permanent (physical impairment/visual impairment/speech & hearing impairment) in relation to
his/her _____.

Note:-

1. This condition is progressive/non-progressive/likely to improve/not likely to improve.*
2. Re-assessment is not recommended/is recommended after a period of _____ months/years.

* Strike out which is not applicable.

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Signature/Thumb impression
Of the patient

Countersigned by the
Medical Superintendent/CMO/Head of
Hospital (with seal)

Recent Attested Photograph
Showing the disability affixed here.

CERTIFICATE OF MENTAL RETARDATION FOR GOVERNMENT BENEFITS

This is to certify that Smt./Kum _____ Son/Daughter
of _____ of _____ Town/City _____
_____ with particulars given below:-

- a) Age
- b) Sex
- c) Signature/Thumb impression

CATEGORISATION OF MENTAL RETARDATION

Mild/Moderate/Severe/Profound
Validity of the Certificate: Permanent

Signature of the Government
Doctor/Hospital with seal
Chairperson Mental Retardation
Certification Board

Recent Attested Photograph
Showing the disability affixed here.

Dated:

Place:

CHAPTER II
CERTIFICATION – LAW & PROCEDURE
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CHAPTER II

CERTIFICATION – LAW & PROCEDURE

Benefits based on proper certificates

2.1. The following cash benefits are admissible under the Act :-

- (a) Periodical payments to an insured person in case of sickness certified by a duly appointed medical practitioner or by any other officer possessing such qualifications and experience as the Corporation may by regulations specify (sickness benefit);
- (b) Periodical payments to an insured woman in case of her confinement or sickness arising out of pregnancy, confinement, premature birth of child or miscarriage (maternity benefit);
- (c) Periodical payments to an insured person in case of temporary disablement resulting from employment injury (temporary disablement benefit);
- (d) Periodical payments to an insured person in case of permanent total or partial disablement (permanent disablement benefit);
- (e) Periodical payments to dependants of an insured person who dies as a result of employment injury (dependants' benefit);
- (f) Payment to the eldest surviving member of the family of a deceased insured person, towards expenditure on his funeral or where the insured person did not have a family or was not living with his family at the time of his death to the person who actually incurs the expenditure on the funeral of the deceased (funeral expenses).

Types of certificates

2.2.1. An insured person claiming sickness benefit or temporary disablement benefit and an insured woman claiming maternity benefit has normally to obtain medical certificates from an Insurance Medical Officer and submit them to the appropriate Branch Office. The ESI (General) Regulations, 1950, provide for the procedure for issue of such certificates and the form to be used on each occasion. These Regulations also provide for the issue of a death certificate which helps in claiming dependants' benefit and funeral expenses. A brief introduction to these forms on which the entire citadel of cash benefits rests, is given below while a detailed discussion will be taken up in the paragraphs that follow subsequently: –

Description	Form used	Purpose and special features
First certificate	7* (formerly form 8)	Issued at the start of spell of sickness of an IP, it normally certifies incapacity for the date of issue only.
Final certificate	7* (formerly form 9)	Issued at the end of the spell of sickness, it normally certifies incapacity for the past week or so and specifies the date of fitness of an insured person.

* Form 7 is a combined first/final/intermediate certificate form which replaces the earlier form 8 (for first certificate), 9 (for final certificate) and 10 (for intermediate certificate) w.e.f. 1.1.2005. In the new form, the portions not relevant in a particular case are to be scored out by the issuing IMO.

Intermediate certificate	7 (formerly form 10)	For extension of leave of an insured person. This is issued at weekly intervals and, like the final certificate, it also certifies incapacity for the past one week or so.
Special intermediate certificate	8 (formerly form 11)	Issued to an insured person suffering from an ailment that will take longer than, say, a month, after his incapacity has already lasted for 4 weeks, this is the only certificate which certifies incapacity in advance.
Death certificate	13 (formerly form 17)	This certificate enables the dependent relatives of a deceased insured person to obtain dependants' benefit and/or claim funeral expenses.
Certificate of pregnancy	17 (formerly form 20)	A pregnant insured woman intending to claim maternity benefit for confinement, etc., may, at her discretion, obtain this certificate.
Certificate of expected confinement	18* (formerly form 21)	An IW, just at the time of proceeding on maternity leave, obtains this certificate which enables her to claim and receive maternity benefit before her confinement.
Certificate of confinement/miscarriage	18* (formerly form 23)	Obtained as proof of confinement/miscarriage, this certificate forms the basis for claiming maternity benefit.
Maternity benefit death certificate	21 (formerly form 24 B)	Obtained as a proof of death of IW leaving behind newborn child. Maternity benefit (Reg. 89A) can be claimed by her nominee on production of this certificate.

2.2.2. Apart from medical certificates prescribed in Regulations, certain other forms have also been prescribed through administrative instructions which can be used in circumstances justifying their issue, the more prominent of those being –

- (i) information to employer about an insured person's sickness/incapacity in form ESIC-Med-11 (Information of Sickness).
- (ii) death certificate in form ESIC-Med-12.

* Old form 21 (certificate of expected confinement) and old form 23 (certificate of actual confinement/miscarriage) have been combined into new form 18. IMO will delete whichever portion is not applicable in each such form.

- (iii) certificate in form ESIC-Med-13 given to an insured person admitted as an inpatient in a hospital, to enable him to obtain cash benefit from the Branch Office.

2.2.3. The Corporation may, in addition, accept any other certificate as evidence of (i) sickness or temporary disablement under proviso to Regulation 53, (ii) confinement, miscarriage, etc., under Regulation 90 or (iii) death under Regulation 95D as the circumstances of each case may justify.

Collective responsibility of IMOs for certification

2.3. *Vide* Regulation 54, no medical certificate under the Regulations shall be issued except by the Insurance Medical Officer to whom an insured person had been allotted or by an Insurance Medical Officer attached to a dispensary, hospital, clinic or other institution to which the insured person is allotted. Such an Insurance Medical Officer shall examine the insured person and if, in his opinion, the condition of the insured person so justifies, issue to him, free of charge, any medical certificate reasonably required by him under or for the purposes of Employees' State Insurance Act and the Regulations or any other enactment.

2.4. Provided that an Insurance Medical Officer may issue a medical certificate under the regulations to an insured person who is not allotted to him or to the dispensary, hospital, clinic or other institution to which he is attached, if such officer is satisfied that in the circumstances of any particular case the insured person cannot reasonably be expected to get medical benefit from the Insurance Medical Officer or the dispensary, hospital, clinic or other institution to which such insured person has been allotted; and such certificate also shall be issued free of charge.

2.5. An insured person shall not be granted a medical certificate unless he produces to the IMO/IMP his identity card or such other document under the regulations which may have been issued in lieu thereof, e. g., the temporary identification certificate etc.

Certificate by IMO on casualty duty

2.6. In an emergency, the Insurance Medical Officer or the Casualty Medical Officer incharge of emergency ESI dispensary, who attends/treats an insured person during emergency duty hours may issue first certificate to the insured person, if in his opinion the insured person needs abstention from work on medical grounds. The number and date of the first certificate is indicated on the prescription so that the IMO/IMP to whom the insured person is attached may issue subsequent certificate as may be necessary.

Completion of certificate

2.7. The appropriate form of medical certificate should be filled in ink or by a ball pen by the IMO/IMP *in his own hand-writing* and should contain a concise statement of the disease or disablement which in the opinion of the IMO/IMP necessitates abstention from work on medical grounds or renders the person temporarily incapable of work. The statement of the disease or disablement in the medical certificate should specify the nature thereof as precisely as the IMO/IMP's knowledge of the condition of the insured person at the time of the examination permits. (Regulation 55). The signature or thumb impression of the insured person should be obtained in the space provided in the certificate. All blank spaces in the certificate should be filled in.

2.8. The certificate should be stamped with the name of the IMO and the name of the dispensary or of Insurance Medical Practitioner alongwith his code number.

Time of granting medical certificate

2.9. An Insurance Medical Officer shall give the medical certificate to an insured person *at the time of the examination* to which it relates. Where he is prevented from doing so, he shall send the certificate to insured person within twenty-four hours thereafter.

2.10. No further medical certificate relating to the same examination shall be issued, except where a duplicate of such certificate is required in which case it shall be issued free of charge and clearly marked "Duplicate". *No ante-dating or post-dating* of certificates is permissible. The date stated as the date of examination must be the date on which the patient is in fact examined. (Reg. 56).

Certification for sickness and temporary disablement

2.11. Books containing blank forms of regulation certificates are supplied by the Regional Director/Branch Manager to each ESI dispensary/panel doctor's clinic either directly or through the Administrative Medical Officer of the State/area. Both the certificates and books are serially numbered and are required to be kept in proper custody by the Medical Officers strictly in accordance with instructions issued by Headquarters from time to time.

Medical certificate on first examination

2.12. When an insured person, on first examination, is found unfit to perform his duty as a result of sickness or temporary disablement and his condition also requires medical attendance and treatment, a first certificate in form 7 is issued to him and this certificate is only for the date of examination. In case a first certificate is not issued at the time of examination but is issued within 24 hours thereafter, the Insurance Medical Officer must clearly state the date of examination in the 'remarks' column of such a certificate as otherwise the insured person will not get sickness benefit for the previous day.

2.13. Where the insured person, who needs abstention from work on the date of examination, states that he has been actually sick or temporarily disabled on a day earlier than the date of his first examination, the Insurance Medical Officer may, if he is satisfied as to the truth of the statement that the insured person was unable to present himself for a medical examination earlier for reasons beyond his control, certify incapacity for work for one day preceding the date of examination. However, 'back period' of 24 hours cannot be certified if the IP is found fit at the time of examination.

2.14. The Director General has relaxed the provisions of Regulation 57 of the Employees' State Insurance (General) Regulations, 1950 to the following extent :-

In areas where the insured persons are served by mobile dispensaries, any period not exceeding three days of incapacity prior to the time of examination may be certified by the Insurance Medical Officer provided the mobile dispensary did not visit the place during that period and the Insurance Medical Officer is satisfied about the incapacity of the insured person during such period.

2.15.1. If a first certificate or a combined first-cum-final certificate covers a back period of more than 24 hours (more than 3 days in respect of an insured person served by a mobile dispensary) before the date of issue, it should ordinarily be accepted only for 24 hours or upto 3 days respectively. If, however, there are special circumstances for which the Insurance Medical Officer has given adequate explanation, the certificate may be accepted by Manager upto 3 days' back period as alternative evidence. Cases covering more than 3 days may be referred to Regional Director who may, in his discretion, accept the back period upto 14 days if circumstances are exceptional and there is no doubt whatsoever about the incapacity of an insured person.

2.15.2 In respect of cases where the back period in the first or first-cum-final certificate exceeds 14 days, the Director General has delegated power to accept certificates of the following categories to the Regional Director/Director/Joint Director (I/c) /Divisional Office incharge:

- (a) Where the back period of incapacity is recommended for more than 14 days before the date of first certificate, provided the need is justified on grounds of clinical emergency preventing the IP in going to IMO, subject to recommendation by SMC/Medical Referee.
- (b) Where the hospital admission/discharge certificate is issued by a Govt. Hospital including Medical College Hospital in case of clinical emergency and admission/discharge certificate is issued in the prescribed proforma of the Govt. Hospital.

- (c) where, in case of clinical emergency, hospital admission/discharge certificate is given by a private hospital in an area where ESI dispensary or hospital is not available, keeping in view the emergency, incapacity may be accepted only for 7 days initially and beyond 7 days, such cases may be accepted for a maximum of 14 days subject to recommendation by Medical Referee.
- (d) The paras described above should be used in case of clinical emergency in such a way as to prevent its misuse by IPs availing of SB/TDB.
- (e) Cases which do not fall under any of the categories mentioned above may continue to be forwarded to Hqrs. Office with the specific recommendation of MR/SMC/RD.

2.15.3. In cases covered by the preceding paras, the remarks regarding back period in the first certificate shall be duly authenticated by the Insurance Medical Officer with his dated signatures below such remarks.

2.16. Further, as per second proviso to Reg.57, if on first examination, the Insurance Medical Officer is of opinion that the insured person will be fit to resume work not later than the 3rd day after the date of examination, he will specify in the first certificate the date on which the insured person will, in his opinion, be fit to resume work. This certificate will then also be treated as a final certificate – also known as first-and-final certificate.

2.17. It may happen that an insured person who was expected to be fit not later than the third day after the date of first examination, and he was also issued a first-and-final certificate, may not actually become fit on the specified date as anticipated. In that case, the IMO/IMP will, after examining the insured person, issue an ordinary intermediate certificate. It will not be necessary to issue another first certificate, the first and final certificate issued earlier being treated as a first certificate.

Final certificate

2.18.1. Every insured person shall obtain a medical certificate in the form of a final certificate before he takes up any work for wages (Reg. 60).

2.18.2. The final certificate is to be issued only in those cases where a first certificate had been issued for the particular spell of incapacity or the insured person produces an admission-discharge certificate from a hospital recognised under the Scheme.

2.19.1. If on the date of examination to which a medical certificate, other than a first certificate, relates, the insured person in the opinion of the Insurance Medical Officer is, or will become on a date not later than the third day after that date, fit to resume work, that certificate shall be in the form of a final certificate (Regulation 58).

2.19.2. Payment of sickness benefit (SB)/temporary disablement benefit (TDB) can be made in advance for date or dates of incapacity certified in a first-cum-final or final certificate, but in all such cases, abstention verification must be made.

Final certificate after IP has resumed duty

2.20. The IMO/IMP shall not issue a final certificate to an insured person who has already resumed duty without obtaining it. However, if he requests for a final certificate, it may be issued after striking off the words “I certify that I have examined you today Cause Group No..... In my opinion you will be fit to resume work tomorrow/on” and indicating in the remarks column the date on which the insured person last attended the dispensary/clinic. Such a certificate is not in accordance with Regulations but is issued for the convenience of the insured person. So, whenever such a certificate is received in the Branch Office, it may be accepted as alternative evidence of incapacity upto the date he attended the dispensary/clinic and payment of benefit regulated accordingly.

Intermediate certificate

2.21. If the final certificate is not issued within seven days of the date of the first certificate, an IP shall, except where the case calls for issue of special intermediate certificate, submit medical certificate in

form of intermediate certificate (form 7 after scoring out portions not relevant at the moment of issue) at intervals of not more than seven days each, commencing from the date of first certificate (Reg. 59).

2.22. When in a particular spell, the Insurance Medical Officer/Insurance Medical Practitioner considers that the need for abstention from work due to a particular cause, e. g., employment injury or maternity, sickness, has ceased but should continue owing to another cause, e. g., sickness, he will record a remark in the intermediate certificate specifying the dates on which need for abstention due to the particular cause terminated and that for the other cause started.

Special intermediate certificate

2.23. Where sickness or temporary disablement of an insured person has continued for not less than twenty-eight days and the IMO/IMP is satisfied that such sickness or disablement is likely to continue for a long period and that, owing to the nature of the sickness or disablement, examination and treatment at intervals of more than one week will be sufficient, the insured person may, unless otherwise directed by the appropriate Branch Office, furnish medical certificates in the form of special intermediate certificates (form 8) at intervals of such longer period not exceeding four weeks as may be specified by the IMO (Reg. 61).

Special intermediate certificate for more than 28 days

2.24. Insurance Medical Officers should not issue special intermediate certificates covering a period of more than 28 days. Such certificates can ordinarily be issued only by Medical Referees. However, there may be instances where an Insurance Medical Officer issues a special intermediate certificate covering a period of more than 28 days. The Branch Office may accept such a certificate provided it does not contain any adverse remarks whatsoever by the Insurance Medical Officer and the period covered does not exceed 42 days. Where the period is longer, the case should be referred to Regional Office for decision.

Hospital cases: certificate by IMO/IMP

2.25. An insured person may need admission to a hospital at the beginning of his spell of sickness or temporary disablement or the need for hospitalisation may arise at a later date when his treatment by IMO/IMP has already continued for some time.

2.26. If an insured person is found to need hospital admission at the time of first examination, the IMO/IMP will issue a first certificate (form 7 after scoring out portions not relevant at the moment) indicating in the remarks column of the certificate that the insured person has been referred to hospital for admission.

2.27. As the number of hospital beds is limited, the insured person may not be admitted immediately but according to priority as and when beds fall vacant. During the waiting period the IMO/IMP may issue certificates if the insured person is in actual need of abstention from work and not merely because the insured person is awaiting admission in the hospital.

2.28. The IMO/IMP would not normally issue any certificate during the period of insured person's stay in the hospital as he would not be in a position to examine the insured person.

2.29. Every insured person after discharge from the hospital has to report to the IMO/IMP immediately with the admission and discharge certificate and the later should issue him an intermediate or a final certificate according as his condition warrants. If an intermediate certificate is issued, further certificates will be issued strictly in accordance with the instructions on issue of intermediate or special intermediate certificates.

2.30. While issuing a certificate to an insured person after discharge from hospital the IMO/IMP will also certify illness for the period of stay in the hospital on the basis of the admission-and-discharge certificate and state in the remarks column "Was admitted in.....Hospital on.....and discharged on..... *Vide* (The No. of the admission-and-discharge certificate)". These remarks will also bear additional signatures and stamp of the IMO/IMP who will also rubber stamp or write in block letters the words "Hospital Case" on top of such a certificate.

2.31. Where an insured person is receiving in-door treatment in an ESI Hospital, Medical Officer attached to such hospital who may be designated as Insurance Medical Officer will issue regulation certificates to the insured person just like the IMO/IMP to whom the insured person is otherwise allotted.

2.32. Where an insured person is admitted to a hospital direct by an employer or otherwise, without the knowledge of his IMO/IMP, first certificate need not be issued in respect of the insured person. After discharge of insured person from hospital, the insured person will report to his IMO/IMP (normally within 3 days) who should issue him final or intermediate certificate according to his condition at that time with the remarks about hospital admission as referred to above.

IP's failure to take treatment or report to IMO/IMP

2.33. Under Section 64 of the Act a person who is in receipt of sickness benefit or temporary disablement benefit –

- (a) shall remain under medical treatment at a dispensary, hospital, clinic or other institution provided under the Act and shall carry out the instructions given by the medical officer or medical attendant incharge thereof;
- (b) shall not while under treatment do anything which might retard or prejudice his chances of recovery;
- (c) shall not leave the area in which medical treatment provided under the Act is being given, without the permission of the medical officer, medical attendant or such authority as may be specified in this behalf by the Regulations; and
- (d) shall allow himself to be examined by any duly appointed medical officer or other persons authorised by the Corporation in this behalf.

Suspension of benefit

2.34. Under Regulation 99, sickness benefit or temporary disablement benefit may be suspended if a person who is in receipt of such benefit fails to comply with any of the requirements of Section 64, and such suspension shall be for such number of days as may be decided by the authority authorised by the Director General in this behalf.

2.35.1. Branch Managers have been delegated powers to suspend benefit under Regulation 99. However, while exercising these powers, they have to clearly understand the distinction between failure of an insured person for which he should suffer penalty and failure of the IMO/IMP to fulfil his obligations for which IP cannot be made to suffer. This has been made clear *vide* Para 6.3.(s) of the Medical Manual-4th edition which reads as under :-

An IP under certified abstention is expected to attend the dispensary or IMP's clinic as advised by IMO/IMP and obtain subsequent certificates on the due date. It is also the responsibility of the IMOs to consider issue of appropriate certificates on due date if IP attends dispensary or clinic.

2.35.2. In this connection, the following broad instructions are laid down for the guidance of BM in cases of failure of an insured person to comply with the requirements of Section 64 reproduced in para 2.33 above:

- I. Certificates issued *timely* or *late* bearing remarks regarding 'due dates' for treatment of insured person, "non-attendance" or "intermittent attendance" but without any indication of aggravation:**

(a) Intermediate certificate:

Ordinarily, benefit should be paid for seven days from the date of previous certificate, unless BM considers that it should be suspended after the due date. BM may allow benefit for the remaining period also upto a total period of 30 days including the first seven days, if he is satisfied about the reasons for delay in reporting to the IMO/IMP. If the period is more than 30 days and BM considers it necessary, a reference may be made to the Regional Office giving full facts and recommendations. The Regional Director may accept as alternative evidence the whole or part of the period if he is satisfied with reasons for delay.

(b) Final certificate:

(i) If the insured person is declared fit for work with effect from some date subsequent to the date of examination, the certificate may be accepted by the Branch Manager for the entire period but not exceeding 30 days, if he is satisfied about the reasons for delay in attending the dispensary. If the period covered exceeds 30 days, reference may be made to Regional Office, as in (a) above.

(ii) If the insured person is declared fit on the date of examination, payment should be made upto and including the due date only. Where the Branch Manager is satisfied about the *bona fides* of the case, he may make a reference to the Regional Director who may accept the whole or part of such certificates as alternative evidence.

(iii) But the foregoing provision will not apply to cases where the issue of certificate was delayed by the mistake of the IMO and benefit would be admissible to IP in full without reference to the Regional Office. An illustration would make this point clear:

Illustration: A first certificate was issued to an insured person on 1.1.09 and a final certificate was issued to him on 12.1.09, declaring him fit on the same date. The certificate bore the remarks on its top "IP failed to request for intermediate certificate on due date". The insured person, on inquiry from IMO, was found to have attended the dispensary regularly. For reasons stated hereinabove, Branch Manager should accept the final certificate as alternative evidence of incapacity and pay him the cash benefit due for the full period of incapacity certified, i. e. 1.1.09 to 11.1.09, if otherwise admissible, without reference to Regional Office.

II. Medical certificate covering more than 7 days and bearing no remarks:

(a) Intermediate certificate:

BM may accept as alternative evidence upto a period not exceeding 30 days an intermediate certificate issued late if he is satisfied about the reason for delay in reporting to the IMO/IMP. If the period is more than 30 days, a reference may be made to the Regional Office giving full particulars and recommendations, if considered necessary.

(b) Final certificate:

(i) If the insured person is declared fit for work with effect from some date subsequent to the date of examination, the certificate may be accepted by the BM for the entire period not exceeding 30 days, if he is satisfied about the reasons for delay in attending the dispensary. If the period covered exceeds 30 days, a reference may be made to the Regional Director who may accept as alternative evidence the whole or part of the period if he is satisfied with the reasons for delay.

(ii) In case of a final certificate declaring the insured person fit on the date of the examination, the certificate should be accepted as alternative evidence upto and including the due date only. Where the BM is satisfied about the *bona fides* of the case, he may make a reference to the Regional Director who may accept as alternative evidence the whole or part of the period covered by such a certificate.

III. Certificates bearing remarks regarding aggravation of disease:

- (a) In case the period of aggravation is specified, benefit should be forfeited for that period even if a part of it is covered by a subsequent certificate. If considered necessary, reference may be made to Regional Director who may restore the benefit on advice from Medical Referee or if he is otherwise satisfied regarding reasons for insured person's failure to attend the dispensary.
- (b) In case the period of aggravation is not specified, benefit should ordinarily be suspended from the date following the 'due date'. If, however, the BM considers it necessary, the case may be referred to the Regional Office with full facts for obtaining the advice of the Medical Referee. If the Medical Referee is satisfied that there is no material aggravation or if the Regional Director is satisfied that there were unavoidable reasons preventing the insured person from attending the dispensary on or after the 'due date', the benefit may be restored.

IV. Medical certificate bearing remarks regarding deliberately avoiding operation and prolonging incapacity:

Such cases may be referred to the Regional Office for taking advice of the Medical Referee. If Medical Referee confirms the opinion of the IMO/IMP, benefit may be forfeited for the period as may be specified by Medical Referee, not exceeding 10 days. If the Medical Referee does not agree with the views of the IMO/IMP, benefit may be paid for the entire period certified.

V. Special intermediate certificate:

BM may accept as alternative evidence a special intermediate certificate issued within 28 days of commencement of the spell of sickness or covering more than 28 days but less than 42 days (or issued late by not more than 14 days) without any remark regarding aggravation, if he is satisfied about the reason for irregular issue of these certificates. A special intermediate certificate covering more than 42 days (or issued late by more than 14 days) may be referred to Regional Director who may, if he is satisfied, accept it as alternative evidence.

VI. Hospital cases:

(A) Delay in getting admission into hospital:

(i) In cases where an insured person is admitted into a hospital after issue of first certificate by Insurance Medical Officer, the uncertified period between the date of issue of first certificate and date of admission in hospital, if upto 6 days (both dates exclusive) may be accepted by BM as alternative evidence on strength of hospital discharge certificate submitted by the insured person. Where the gap is more than 6 days, the case should be referred to Regional Director who may accept it as alternative evidence in consultation with the Medical Referee.

(ii) Where insured person is admitted in hospital after some days from issue of an intermediate or special intermediate certificate, the gap period upto 15 days may be accepted as alternative evidence by BM if he is satisfied about the non-availability of the admission. If

the gap exceeds 15 days, reference may be made to Regional Director who may accept the entire period as alternative evidence in consultation with Medical Referee.

(B) Delay in reporting to IMO/IMP after discharge from hospital:

(a) Final certificate issued by IMO/IMP:

Where the hospital authorities do not recommend any rest/convalescence period after discharge of the insured person from the hospital, only the period covered by the hospital discharge certificate will be accepted by BM as alternative evidence, irrespective of the date of issue of final certificate. However, where the intervening period between the date of discharge and the date of examination by the IMO/IMP is upto 3 days (both days exclusive), the Manager may accept the intervening period as alternative evidence.

Where the hospital authorities have recommended rest/convalescence, the entire period of convalescence/rest may be accepted as alternative evidence by BM irrespective of any time limit on the basis of discharge certificate/medical certificate issued by the hospital provided the insured person has not approached the IMO/IMP after discharge from the hospital. Where the insured person reports to IMO/IMP after discharge from hospital, the period of rest/convalescence so recommended or the period upto the issue of final certificate whichever is shorter may be accepted as alternative evidence by BM. Where, however, there is delay in reporting to IMO/IMP, the intervening period between the date of discharge and the date of examination by the IMO/IMP, if in excess of 3 days, may be accepted as alternative evidence by the Manager, if such intervening period is certified by IMO/IMP.

(b) Intermediate certificate issued by IMO/IMP:

If delay in reporting to IMO/IMP is upto 15 days the gap may be accepted as alternative evidence by BM if he is satisfied about the reasons for delay. If hospital authorities have recommended rest/convalescence, the period between the date of expiry of rest/convalescence recommended by the hospital authorities and the date of the issue of intermediate certificate upto 15 days may be accepted as alternative evidence by BM. If such delay is more than 15 days, the case may be referred to Regional Director who may accept the entire period in consultation with the Medical Referee.

2.36.1. Whenever BM exercises any discretion in accordance with the above instructions, he should briefly record the reasons justifying the same on the medical certificate/claim, except in case where the delay in the issue of the certificate is upto 7 days or where the irregularity in hospital admission or discharge case covers a period of not more than 6 days.

2.36.2. In order to prevent any fraudulent issue of certificates of admission and discharge as well as payment of cash benefit on such certificates, the following drill should be strictly followed by every Branch Office and any case of fraudulent payment/active collusion of the staff should be brought to the notice of Headquarters office with full details besides taking disciplinary/preventive action against the concerned official :-

- (1) All admission and discharge certificates issued by the ESI Hospital/Govt. hospital/private hospital should be diarised separately in a register in the Branch Office before they are admitted for payment.
- (2) No payment for the period of admission and discharge should be made unless the certificate has been submitted in original or copy of the discharge certificate is attached with the regulation certificate duly countersigned by the IMO/IMP who issues regulation certificates.

- (3) Where payment is made on the basis of original admission and discharge certificate or on the copy of certificate of admission and discharge, abstention verification should be got done in each case. In cases of doubt, verification may also be made from hospital authorities/records.

Enforcement/relaxation of Reg. 64

2.37. Regulation 64 reads as follows :

“Failure to submit medical certificate. – If a person who intends to claim sickness benefit or disablement benefit for temporary disablement fails to submit to the appropriate Branch Office by post or otherwise the first medical certificate or any subsequent medical certificate within a period of three days from the date of issue of such certificate he shall not be eligible for that benefit in respect of any period (i) in the case of a first certificate, more than three days before the date on which the certificate is submitted to the appropriate Branch Office; (ii) in the case of a subsequent certificate, more than fourteen days before the date on which such subsequent certificate is submitted to the appropriate Branch Office:

Provided that the appropriate Regional Office or other office as authorised by the Director General may relax all or any of the provisions of this regulation in any particular case, if it is satisfied that the delay in submitting a certificate was due to *bona fide* reasons.”

2.38. The Director General has authorised the appropriate Branch Office to relax Regulation 64 in all cases, but this relaxation is to be exercised only by the Branch Manager (or the Deputy Manager).

2.39. As the power to relax Regulation 64 has been delegated to the Branch Managers, it is necessary for them to know the object of Regulation 64 and circumstances in which it should be relaxed. The main object of Regulation 64 is to compel the insured person on pain of penalty to submit medical certificates promptly after their issue, so that the Corporation can, if any doubt arises, arrange to have the IP examined by the Medical Referee as soon as possible and, in any case, before the incapacity period is over. Insistence on prompt submission of certificates enables the Corporation to verify the incapacity much sooner than would otherwise be possible. Branch Offices are required to initiate priority incapacity reference immediately on receipt of the first certificate in suspected cases and the Medical Referee is required to examine these insured persons on priority basis. These instructions are designed to ensure that Regulation 64 is fully utilised as an instrument for discouraging malingering.

2.40.1. In order to avoid hardship to insured persons who may delay submission of certificates merely due to ignorance and thus forfeit their benefit and at the same time to enforce the provisions of Regulation 64, the Corporation amended the certificates in form 8, 9, 10 and 11 *vide* Notification published in Gazette of India, Pt. III, Section 4 dated 15.3.80, and added the following words on top of each certificate:

“Deposit this certificate within 3 days with Branch Office to avoid possible loss of benefit under Regulation 64”.

2.40.2. The Branch Manager should insist on compliance with Regulation 64 and the power to relax this regulation should be exercised in accordance with the spirit of the proviso thereto, which permits relaxation to be granted only if the delay in submitting the certificate is for *bona fide* reasons.

2.41. Relaxation should normally be refused in the following type of cases :-

- (i) Where the insured persons plead ignorance of requirement of Regulation 64 except during the first two years of implementation of the Scheme in any area.
- (ii) Where the insured persons plead forgetfulness.

- (iii) Where the insured person pleads that he asked someone else to deposit the certificate but he delayed its submission. However, the regulation may be relaxed where the insured person was really too sick to call personally at the Branch Office and had no member of the family who could deposit the certificate in accordance with his desire.
- (iv) Where the insured person pleads that the certificates were submitted through the employer. However, if the enquiry from the employer confirms that the insured person's statement is correct, the regulation may be relaxed.
- (v) Where the insured person pleads that he misplaced the certificate, and
- (vi) Where the submission of the certificate has been unduly delayed, say for more than 3 months. In these cases, unless there are special circumstances, no relaxation should be made.

2.42. The following instructions are laid down in regard to the interpretation of Regulation 64 and the procedure to be followed in regard to its enforcement or relaxation:

- (i) If the last day for submitting a certificate is a holiday, the certificate will be deemed to have been submitted in time if it is received in the Branch Office on the next working day.
- (ii) The date of submission of a certificate is the date on which it is actually received at the Branch Office and not the date on which it is posted by the insured person.
- (iii) A certificate submitted in time at any office of Corporation shall be deemed to have been submitted in time to the appropriate Branch Office.
- (iv) Certificates deposited with the clerk of the ESI dispensary at a place where no Branch Office functions and where a Pay Office functions at the dispensary premises, or those deposited in the box provided for the purpose may be date-stamped daily by the dispensary clerk even though they may be despatched to the appropriate Branch Office on prescribed days. The date stamp affixed by the dispensary clerk may be taken as the date of receipt of medical certificates in the Branch Office for the purpose of Regulation 64.
- (v) The submission of the certificate to an employer will not, for the purpose of Regulation 64, be treated as its submission to the Branch Office.
- (vi) The combined first and final certificate is to be treated as a final certificate for the purpose of Regulation 64.
- (vii) Under Regulation 64, if a certificate is delayed, no benefit is payable for any period more than 3 days or more than 14 days (as the case may be) before the date of submission of such delayed certificate. Thus, when Regulation 64 is not relaxed, late submission of a certificate may involve forfeiture of benefit on another certificate in the same spell even though such other certificate is submitted in time. This fact should be borne in mind when refusing relaxation of Regulation 64. In other words, if relaxation of Regulation 64 is refused on any delayed certificate, relaxation should automatically be allowed on other certificates in the spell if they have been submitted in time.

2.43. The Manager need not refer any case to the Regional Office for decision unless there is any specific doubt or difficulty. Similarly, the Regional Director need not refer any case to the Headquarters except where guidance of the Headquarters is felt to be absolutely necessary.

2.44. Before considering relaxation of Regulation 64, BM may, if he so desires, ask for a written statement from the insured person, stating reasons for delay. But this is not essential and Manager may relax the Regulation after personally interrogating the insured person and being satisfied about the reasons. He should briefly record on certificate the fact that he has interrogated the insured person and satisfied himself about the reasons.

2.45. The fact that Regulation 64 has been relaxed should be recorded on the Medical Certificate itself by the Manager over his signature. No remarks need be recorded on the certificate if Regulation 64 has not been relaxed.

2.46. Enforcement of Regulation 64 specially in respect of subsequent certificates presents some difficulties. Here is a list of steps required for most such cases and once these steps are mastered, enforcement of this regulation will be easy. The accompanying illustration is of a spell of sickness/temporary disablement from 1.3.09 to 15.3.09 wherein only the final certificate dated 15.3.09 was submitted late on 25.3.09.

Steps		Illustration
Step 1.	Mark down date of issue of the subsequent certificate	15.3.09
Step 2.	Write down date of its submission	25.3.09
Step 3.	Before this date, write down dates first and last of 14 days	11 to 24.3.09
Step 4.	Write down the period covered by delayed certificate	9 to 15.3.09
Step 5.	Write down dates given in step 4 which occurred before date in the step 3	9 to 10.3.09

Benefit will be suspended for 9 and 10.3.09.

2.47. A few solved examples are added below alongwith reasoning leading to conclusion, for the benefit of readers :-

Example 1 – Shri Jose Mario

<i>Nature of Certificate</i>	<i>Date of issue</i>	<i>Date of submission</i>	<i>Date for which benefit to be forfeited</i>	<i>Remarks and Reasoning</i>
1 st	1.3.09	10.3.09	1.3.09	The first certificate is delayed. Benefit can be forfeited for all days upto 6.3.09. But the intermediate certificate dated 8.3.09 which covers the period 2 to 8.3.09 has been submitted in time. Here, benefit can be forfeited only for one day. Forfeiture of even this one day becomes infructuous unless the spell is of sickness falling within 15 days of a previous spell of sickness for the whole or part of which sickness benefit was paid
Int.	8.3.09	10.3.09		
Final	15.3.09	18.3.09		

Example 2 – Shri Yusuf F.

1 st	1.3.09	4.3.09	Nil	The intermediate certificate is submitted late. But the language of Regulation 64 makes the penalty ineffective because benefit is forfeitable for fifteenth and earlier days before submission, viz, 28.2.09 on which date insured person was not on certified sickness.
Int.	8.3.09	15.3.09		
Final	15.3.09	18.3.09		

Example 3 – Jivabhen

1 st	1.3.09	4.3.09	Nil	For intermediate certificate dated 8.3.09, please see previous example. For intermediate certificate dated 15.3.09, penalty becomes infructuous as period upto 8.3.09 is covered by previous intermediate certificate.
Int.	8.3.09	15.3.09		
Int.	15.3.09	22.3.09		

Example 4 – Kewal Singh

1 st	1.3.09	4.3.09	Nil	All subsequent certificates have been submitted together which indicates the possibility of <i>mala fide</i> intention of insured person to avoid examination by Medical Referee.
Int.	8.3.09	29.3.09	2 to 8.3.09	
Int.	15.3.09	29.3.09	9 to 14.3.09	
Int.	22.3.09	29.3.09		
Final	29.3.09	29.3.09		

Irregular certificates – acceptance as alternative evidence

2.48.1. Certificates of the following types are accepted as alternative evidence by BM:

- (i) A first-cum-final certificate covering a back period of more than one day.
- (ii) An intermediate or a final certificate issued covering a period of more than 7 days after the issue of previous certificate.
- (iii) A special intermediate certificate issued by IMO/IMP within 28 days of commencement of the spell or covering more than 28 days but not exceeding 42 days.

2.48.2. If submission of any such certificate is delayed beyond 7 days from the date of issue, benefit should be forfeited for the number of days by which the delay in submission of the certificate exceeds 7 days. An illustration will make the foregoing clear :-

An insured person was issued the following certificates which he deposited on dates mentioned against each:

1st dated 1.3.09 deposited on 1.3.09

Int. dated 12.3.09 (leave in continuation) and

Final dated 19.3.09, both deposited on 22.3.09

Benefit on intermediate certificate dated 12.3.09 forfeited for : 22-19 = 3 days.

Application of Reg. 64 to duplicate certificate

2.49. Duplicate certificates issued by the IMO/IMP in the event of loss or misplacement of original certificates fall into two categories namely:-

- (i) those covering 7 days or less
- (ii) those covering more than 7 days

Reg: (i) above, duplicate certificates of the first category are regulation certificates issued under Regulation 56 (b), and, therefore, Regulation 64 applies to them as it applies to original certificates.

Reg: (ii) above, the duplicate certificates of the second category are accepted as alternative evidence and the penalty specified in para 2.37 above should be applied to them in the same way as it applies to original certificates covering more than 7 days. In other words, where the submission of such a duplicate certificate is delayed beyond 7 days, benefit shall be forfeited for the number of days by which the delay in submission of duplicate certificates (not the original certificates) exceeds 7 days *vide* para 2.48.2 above.

Delay in submission of hospital discharge certificate

2.50. Branch Offices have been authorised to accept discharge certificates issued by recognised hospitals as alternative evidence. No time limit for submission of these certificates has been laid down in the Regulations. As the possibility of malingering in hospital cases is negligible, BM may accept such a certificate and make payment of cash benefit if it is submitted within three months from the date of issue, without making any reference to the Regional Office. Certificates delayed by more than three months should be referred to the Regional Office for decision.

Alternative evidence of incapacity

2.51. Regulation 53 reads as follows:

“Evidence of sickness and temporary disablement. 53.- Every insured person claiming sickness benefit or disablement benefit for temporary disablement, shall furnish evidence of sickness or temporary disablement in respect of the days of his sickness or temporary disablement by means of a medical certificate given by an insurance medical officer in accordance with these regulations in the form appropriate to the circumstances of the case.

Provided that in areas where the arrangements for medical benefit under the Employees’ State Insurance Act have not been made or otherwise if in its opinion the circumstances of a particular case so justify, the Corporation may accept any other evidence of sickness or temporary disablement in the form of a certificate issued by the medical officer of the State Government, local body or other medical institution, or a certificate issued by any registered medical practitioner containing such particulars and attested in such manner as may be specified by the Director General in this behalf”.

2.52. The Director General has authorised the Regional Directors, Deputy Directors, Asst. Directors and the Branch Managers to accept alternative evidence of sickness and disablement in accordance with the administrative instructions and guide-lines given below:

- (1) A certificate issued by a registered medical practitioner other than an IMO/IMP practising in an area where the insured person works and resides and where arrangements for medical care have been provided by the Corporation should not be accepted.

- (2) The following may be considered as suitable alternative evidence of sickness or temporary disablement:
- (a) A certificate from the medical officer incharge of state, local body or other medical institution in the locality, indicating name and designation of the issuing authority.
 - (b) A certificate from any registered medical practitioner (including registered vaid and hakims) attested by the village headman, lambardar or head of the gram panchayat over the seal of the panchayat, and where there is no village headman or gram panchayat, by any government official or a Municipal Commissioner. The certificate should contain the full name, address and registration number of the medical practitioner.
 - (c) A medical certificate from a foreign country may also be accepted by the Regional Director himself and by BM after close scrutiny and careful examination of each case in accordance with the broad principles laid down for acceptance of alternative evidence.

2.53. The following further instructions should be borne in mind :-

- (i) Certificates from outstation should not be accepted as alternative evidence by the BM if the insured person was under the treatment of the IMO/IMP at the time of his leaving the place of his residence, unless the IMO/IMP had specifically recorded on the certificate last issued by him that the IP was permitted to leave station. Hard cases may be referred to the Regional Office for consideration with full facts and BM's recommendations.
- (ii) No alternative evidence certificate should be accepted by BM under his own authority for more than 30 days. The limit of 30 days applies, not to the whole spell covered by alternative evidence certificates, but to a single certificate in the spell. Ordinarily, the alternative evidence should certify incapacity in arrears except in the case of the certificate submitted for the first time during the spell of sickness. Where a certificate is submitted in advance of any period, and the insured person fails to produce a subsequent certificate or a fitness certificate, the period covered by the advance certificate may be accepted by the BM if it does not exceed one week and if he is satisfied about genuineness of the case. In other cases, the certificate may be referred to the Regional Director who may decide the case in consultation with the Medical Referee.
- (iii) In respect of certificates issued by registered medical practitioner back* period upto 24 hours may be accepted by BM and any period more than that may be referred to Regional Office where the same could be accepted in consultation with Medical Referee or Regional Dy. Medical Commissioner. Normally, acceptance of such back periods should not be encouraged except where circumstances of a particular case justify such a course of action.
- (iv) The following delegation has been made for acceptance of 'back period' certified by hospitals and other institutions (e. g., registered medical practitioners) :-

For non-regulation certificates

(a) Certificates issued by hospitals:

Powers delegated to

- (i) Branch Manager for back period upto 3 days.
- (ii) R. O. for period in excess of 3 days

* Back period refers to such situations where incapacity is certified for the date preceding the date of examination or the commencement of treatment. This means that incapacity is certified for a period during which insured person was not under treatment, but merely on the statement of the insured person, such a period occurring prior to the date of examination.

- (b) Certificates issued by institutions other than at (a) above
 - (i) Branch Manager upto 1 day back period.
 - (ii) R. O. where the back period is in excess of (i) above.
- (v) Every certificate submitted as alternative evidence should reach the Branch Office *within 10 days of the date of issue*. Certificates received late should ordinarily be rejected. Delay upto 30 days may be condoned if there is evidence that the medical certificates were sent to the employer within 10 days of the date of issue.
- (vi) Where emergency treatment is provided under Regulation 69 of the Employees' State Insurance (General) Regulations, 1950, by the employer and notice is sent immediately to the Branch Office, and the IMO/IMP has not been able to see the patient for *bona fide* reasons inspite of the notice being given, a suitable alternative evidence from the employer's doctor may be accepted by the Branch Manager for a period not exceeding 7 days.
- (vii) If the insured person has sent certificates regularly, the benefit of doubt may be given to him. If the medical certificates have not been coming regularly, the benefit of doubt will be against the insured person.
- (viii) Where the diagnosis on the medical certificate is vague and there is no previous history of the disease mentioned, the alternative evidence should, if at all, be accepted only after careful scrutiny. The certificates submitted in the past may also be looked into.
- (ix) An enquiry should be made from the employer to ascertain whether the insured person was on leave with wages. If so, the alternative evidence for the period of leave with wages will be rejected outright in the light of amended provisions of Section 63.
- (x) If necessary and practicable, the insured person should be interviewed personally by the BM before recording a decision on a claim based on alternative evidence of sickness.

2.54. When communicating to an insured person the decision in an alternative evidence case, the reason for non-acceptance need not ordinarily be indicated. Where, however, the evidence can be accepted on fulfilment of a technical flaw, e. g., absence of date or of attestation, the defect should be pointed out and an opportunity may be given to the insured person to rectify it. Certificate may be returned with covering letter in form ESIC-44. This should, however, be done only in such cases where the certificate could otherwise be accepted on merits, but for the technical flaw. A case which is not fit for acceptance even after removal of the flaw should not be referred to insured person as it would cause needless resentment and inconvenience.

2.55. An outside certificate submitted by an insured person who has in the past also done so regularly, should be checked up for genuineness. Further, if a particular medical practitioner from a particular place is found to be issuing an unusually large number of certificates, all certificates coming from him should be checked. On the other hand, certificates issued by public hospitals or dispensaries and reputed medical institutions can be accepted if otherwise satisfactory unless the facts and circumstances of the case justify rejection. BM's decision should be recorded on form ESIC-127 (Annexure I). Where case is to be referred to Regional Office, BM should use the aforesaid form and give his recommendations in it. On acceptance or rejection of the alternative evidence, as the case may be, all concerned will be suitably informed. Interim information meant for employer, if requested for by the IP, will be provided by the Branch Office in the form suggested at Annexure II.

2.56. Cases not covered by the above instructions and where the Manager feels that special circumstances exist for the favourable consideration of any of them, should be referred to Regional Office.

2.57. A decision already taken by Manager on a case of alternative evidence will not be reviewed at his level. However, a case deserving a review should be referred to Regional Office with full justification.

2.58. Only Manager (or Deputy Manager) has power to accept alternative evidence; he cannot redelegate the power to any other member of the staff. Record of alternative evidence certificates received and decided is to be maintained in the register in form ESIC-62 (copy at Annexure III).

2.59.1. Acceptance memoranda on cases of alternative evidence referred to Regional Office will be invariably conveyed to the Branch Manager under the signatures of a Branch Officer and not by the Head Clerk concerned. Original medical certificates of alternative evidence will be retained at the Regional Office.

2.59.2. Some insured persons, aggrieved by non-acceptance of their cases by the Branch Office and/or Regional Office, appeal to Hqrs., which calls for the papers for review. Before supplying details of such cases, Medical Referee's opinion on the consistency of diagnosis with period of incapacity should be obtained. Where, however, decision to reject a case rests solely on non-medical facts, e. g., past claims record of an insured person, Medical Referee's opinion need not be obtained. Reasons for non-acceptance/rejection of alternative evidence of incapacity should be stated.

Certification for Maternity Benefit

2. 60 The Regulations provide for the issue of certificates described below to enable insured women to claim maternity benefit:-

Regulation No.	Description	Purpose / Implication	Form No.	
			Prior to 1.1.05	w.e.f. 1.1.05
87	Certificate of pregnancy	Obtaining it is discretionary for IW, but it helps her establish the genuineness & duration of her pregnancy	20	17
88(i)	Certificate of expected confinement	Its timely submission helps IW to obtain maternity benefit if she stops work before her confinement	21	18
88(iii)	Certificate of confinement	As proof of her confinement	23	18
89	Certificate of confinement / miscarriage	As proof of her miscarriage before or during 26 th week of pregnancy or of her confinement	23	18
89A	Certificate of death of IW after confinement leaving behind child	It helps her nominee to claim maternity benefit for the period not availed by IW or, if the child also dies, until the date of its death whichever is earlier.	24A	21

Detailed instructions on claiming maternity benefit based on these certificates may be seen in Chapter IX – Maternity Benefit – Law & Procedure. In addition to these certificates, an IW's claim for sickness arising out of pregnancy / confinement/ premature birth of child or miscarriage has to be supported by the certificates of sickness in new forms described in the foregoing paragraphs.

Other evidence in lieu of a certificate

2.61. Under Regulation 90, the Corporation may accept any other evidence in lieu of a certificate of pregnancy, expected confinement, confinement, death during maternity, miscarriage or sickness arising out of pregnancy, confinement, premature birth of child or miscarriage by an Insurance Medical Officer if, in its opinion, the circumstances of any particular case so justify.

Authority for issue of certificate

2.62.1. Under Reg. 94, no certificate connected with maternity benefit shall be issued except by the IMO to whom insured woman is or had been allotted, or by an IMO attached to a dispensary, hospital, clinic or other institution to which the insured woman is or was allotted, and such IMO shall examine her and if, in his opinion, the condition of the woman so justifies, or in case of death of the insured woman or death of the child if satisfied about such death, issue to such insured woman or in case of her death to her nominee or legal representative, as the case may be, free of charge, any such certificate when reasonably required by such insured woman or her nominee or legal representative, as the case may be, under or for the purposes of the Act.

2.62.2. Provided that such officer may issue such a certificate to or in respect of an insured woman who is or was not allotted to him or to the dispensary, hospital, clinic or other institution to which such officer is attached, if such officer is attending the woman for prenatal care, for confinement, for miscarriage or for sickness arising out of pregnancy, confinement, premature birth of child or miscarriage or in the case of death, was attending the deceased insured woman or the child at the time of her/its death.

2.63. The second proviso to Regulation 94 says that a certificate of pregnancy, or expected confinement, or confinement, or miscarriage required under the Regulations may also be issued by a registered midwife and shall be accepted by the Corporation on counter-signature by the Insurance Medical Officer.

Certificate for PDB

2.64. Instructions on this subject are contained in Chapter V – Permanent Disablement Benefit Law and Procedure.

Certificate for dependants' benefit

2.65. Any person claiming dependants' benefit has to submit a death certificate in respect of a deceased insured person. The IMO/IMP attending the deceased person at the time of his death or an IMO/IMP who examines the body after death shall issue free of charge a death certificate in form 17 (form 13 w.e.f. 1.1.05) to the dependants of the deceased. Death certificate in form 13 may also be issued by the Medical Officer who attended the insured person in a hospital or other institution where such insured person dies. A report of issue of the death certificate should also be sent by IMO/IMP to the appropriate Regional Office/Branch Office (Reg. 79).

Certificate in case of funeral expenses

2.66. A person claiming funeral expenses has to submit alongwith his claim a death certificate in form 13, issued by the IMO/IMP. The Corporation may accept any other evidence in lieu of death certificate by the IMO/IMP if, in its opinion, the circumstances of any particular case so justify. For details or the types of alternative evidence acceptable as proof of death please refer to the Chapter X – Funeral Expenses – Law & Procedure.

Non-Regulation certificates

2.67. Where in-patient treatment lasts for a long period say over 3 weeks the hospital authorities will issue, at the request of insured person, certificate on Form ESIC-Med-13 to enable him to claim cash benefit. The IMO/IMP may also issue a regulation certificate to an insured person undergoing treatment in a hospital after a visit to him in the hospital, if requested by the insured person.

2.68.1. The IMO/IMP, while issuing medical certificate, will also issue information of sickness in form ESIC-Med-11. This certificate/information is meant for the employer for sanctioning the leave considered necessary for the insured person by the IMO/IMP. No cash benefit can, however, be claimed on ESIC-Med-11. The General Duty Medical Officer of the ward of a hospital in which an insured person is undergoing inpatient treatment may issue on the request of the insured person, an information of sickness in ESIC-Med-11 which is meant for the employer. The approximate period for which insured person is expected to need inpatient treatment may be mentioned in col. (i) of the form and col. (ii) may be scored off. Blank books of ESIC-Med-13 and ESIC-Med-11 also, where necessary, will be supplied to all recognised hospitals by Regional Director/ Administrative Medical Officer.

2.68.2. ESIC-Med-11 has like-wise to be issued to an insured woman in respect of her sickness arising out of her pregnancy, confinement, premature child-birth or miscarriage in addition to certificates on regulation form 7, etc. Besides the foregoing, IMO will issue form ESIC-Med-11 (with suitable modifications) at the time of issue of regulation certificates on forms 18 (certificate of expected confinement) and again form 18 (after confinement) as certificate of confinement. She will, on her own, submit ESIC-Med-11 to her employer (i) to enable him to make suitable substitute arrangement and (ii) to prevent disciplinary action by employer for her continued absence from duty which is for *bona fide* reasons. However, a final/fitness certificate will be required only when leave was given on grounds of sickness.

2.69. In the event of death due to sickness or accident (other than employment injury), a certificate could also be issued by an IMO/IMP on form ESIC-Med-12 to a person representing the deceased.

Further certificate by Medical Referee

2.70. After examination of an insured person as a case of incapacity reference, if the Medical Referee finds him fit for work, he will issue a certificate on Form RM-10 indicating that he does not need abstention from work, to enable the insured person to report for duty straightaway.

2.71. Medical Referee is also authorised to issue any special intermediate certificate to an insured person covering more than 28 days or before 28 days of the spell.

Scrutiny of certificates at the Branch Office

2.72. Every medical certificate received in the Branch Office shall be scrutinised carefully with a view to ensuring that –

- (i) it is on the appropriate form and if not or on a form other than the appropriate form, it has been duly corrected by the IMO under proper attestation and after providing the necessary particulars and crossing those not relevant and that the said certificate is issued by the authorised person as laid down under Regulation-54;

- (ii) the diary mark on it establishes that it was received within 3 days in case of first certificate and within 7 days in case of subsequent certificate;
- (iii) it contains full particulars of the insured person such as his name, insurance number, his signatures/thumb impression (on top); if a first certificate, it contains his employer's code number; if insurance number is not given, it contains other particulars like father's name, employer's name and code number;
- (iv) the reason stated for abstention from work is not vague, e. g., coryza, fever, cold, myalgia, etc., particularly in the intermediate certificate which would ordinarily necessitate an incapacity reference;
- (v) stamp of dispensary has been affixed; also the name of the signing medical officer has been stamped or written in block letters;
- (vi) the certificate has been written in ball point pen by the signing medical officer himself; if the certificate is in form 7 (after suitable modifications).
- (vii) the certificate is complete in all respects, contains no unattested overwritings; any remarks given thereon are attested with full signatures of the medical officer. (His signature can be checked from the specimen signatures provided to the Branch Office);
- (viii) the certificate has serial number and book number out of the books issued for use.

Back reference to IMO/IMP

2.73. A minor defect noticed in a certificate, such as an error in recording insurance number or spelling in name, etc. while all the other important particulars have been correctly entered, may be corrected by the Manager and attested by him. Certificates having such defects as cannot be rectified on the spot at the Branch Office should be referred back to IMO/IMP with a letter for needful.

Plain paper certificates

2.74.1. Plain paper certificates should be accepted only when the stock of printed certificates is exhausted both in the Administrative Medical Officer's Office and also in the Regional/Branch Office. These plain paper certificates should contain all particulars required in regulation certificates and must conform to the regulations in regard to the duration, date of issue, date of submission etc. Also these should be given a local serial number by the IMO/IMP concerned so that these can be identified at any time and unauthorised certificates are not issued for one and the same period of sickness. The authority to accept such certificates will be the Regional Office.

2.74.2. The exhaustion of printed certificate books with the Insurance Medical Officer will not normally be accepted as a reasonable excuse for issue of certificates on plain paper. Moreover, exhaustion of stocks of books may cause serious hardship to deserving insured persons. It will, therefore, be incumbent both on Regional Office/Branch Office and the AMO and with every IMO/IMP to plan supplies in such a manner as never to fall short of certificate books.

EMPLOYEES' STATE INSURANCE CORPORATION

Sub:- Alternative evidence of incapacity

Name & Insurance No.

Dispensary.....

Employer's Name & Code No.

Latest address of the IP.....

<i>Particulars</i>	<i>Replies</i>
--------------------	----------------

1. Whether the IP was under IMO's treatment before leaving if so –
 - (a) Total period of certified incapacity and date of issue of last medical certificate
 - (b) Diagnosis
 - (c) IMO's remarks, if any, on the last certificate
 - (d) Whether IMO's prior permission was obtained

2. Particulars regarding medical certificates submitted as alternative evidence –
 - (a) Date of issue
 - (b) Date of submission in the Branch Office
 - (c) Diagnosis as mentioned in the medical certificate
 - (d) Whether there is any previous history of the said disease, if so, please describe the same briefly.

3. Whether alternative evidence submitted previously regarding the same spell, if so –

(a) Period covered by such spell

(b) Decision of the Regional Office/Branch Office

(c) Reference to Regional Office communication

4. Whether the IP is debarred under Regulation 103-A

5. (a) No. of days for which sickness benefit drawn during the preceding and current benefit periods

(b) Period for which alternative evidence submitted for any different spells on a previous occasion during last 3 years

From to
Accepted/rejected

From to
Accepted/rejected

From to
Accepted/rejected

6. Recommendations of the office

7. Date of interview call, if any

8. Result of interview

9. Decision of the Manager

10. Any other remarks

Branch Manager

Dated.....

BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Sh./Smt. insurance number employed in M/s has submitted a certificate of incapacity from a medical practitioner other than Insurance Medical Officer for the period from to, for acceptance as alternative evidence of incapacity under proviso to Regulation 53 of the ESI (General) Regulations, 1950 and the same is under consideration for acceptance or otherwise.

BRANCH MANAGER

Annexure-III
(See Para 2.58)

ESIC-62

EMPLOYEES' STATE INSURANCE CORPORATION

Register of alternative evidence

Date	Name of the insured person	Insurance number	No. of days for which AE is submitted	No. of days for which AE is accepted	Date of reference to Regional Office	Date of receipt from Regional Office	Nature of decision	Remarks
1	2	3	4	5	6	7	8	9

CHAPTER III
GENERAL CLAIMS LAW

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CHAPTER III

GENERAL CLAIMS LAW

Introduction

L.3.1. Every claim for a benefit payable under the Act is to be made in writing in accordance with the ESI (General) Regulations, to the appropriate Branch Office on form appropriate for the purpose of the benefit for which the claim is made, or in such other manner as the appropriate office (herein the appropriate Branch Office) may, subject to its being in writing, accept as sufficient in the circumstances of any particular case or class of cases. The authority for accepting such other claims rests with the Branch Manager or the Deputy Manager and is not to be exercised by other members of the Branch Office staff. Assistance for filling in the claim form in case of insured persons who cannot do so themselves is to be provided at the Branch Office (Regulation 44).

Claim forms

L.3.2. The appropriate forms prescribed for claiming benefit as revised in the light of ESIC Notification No. N-11/13/2/2003-P&D dated 15.12.2004 (effective from 1.1.05) are as follows :-

A.	Sickness benefit/temporary disablement benefit (SB/TDB)/ Maternity benefit for sickness	Form old Nos. 12, 13 and 14 12A, 13A, 14A	New Nos. 9
B.	(1) Maternity benefit	Form 22 and 24	19
	(2) Maternity Benefit after death, leaving behind child who may be alive or may have died	Form 24A	20
C.	Dependants' benefit		
	(1) First claim	Form 18	15
	(2) Claim for periodical payments	Form 18A	16
D.	Permanent disablement benefit	Form 25	14
E.	Funeral Expenses	Form 25A (Regulation 95E)	22

Availability of claim forms

L.3.3. Claim forms for sickness benefit, temporary disablement benefit and maternity benefit are printed at the bottom/on the reverse of the appropriate certificates issued by the IMO/IMP. However, separate claim forms can also be made available to intending claimants from such persons and such offices of the Corporation as it may appoint or authorise for that purpose, and shall be supplied free of charge. These forms are available at each Branch Office. (Regulation 46).

Claim on wrong form

L.3.4. Where a claim for any benefit has been made on an approved form other than the form appropriate to the benefit claimed, the Corporation (i. e., appropriate Branch Office) may treat the claim as if it was made on the appropriate form: provided that that office may in any such case require the claimant to complete the appropriate form (Regulation-47).

Claim for inappropriate benefit

L.3.5. Where a person makes a claim for any benefit other than that to which he may be entitled under the Act, such a claim may be treated as a claim in the alternative for that other benefit. This may arise in a case like maternity benefit for sickness where the insured woman may have applied for benefit for ordinary sickness benefit. Similarly, it may cover cases where an insured person may submit claim for temporary disablement benefit, and if it is not found admissible, the claim may be treated as one for sickness benefit, if otherwise due (Reg. 50).

Evidence in support of claim

L.3.6. Every person who makes a claim for any benefit has, in addition to medical certificate and other forms specifically required under the Regulations, to furnish such other information and evidence for the purpose of determining the claim as may be required by the appropriate office and, if reasonably so required, has to attend at such office or place as the appropriate office may direct. The Branch Office to which the insured person is attached or the Regional Office will be the appropriate office for this purpose (Regulation-48).

Defective claim

L.3.7. If in the absence of due signature or of due certification, a claim is found defective on the date of its receipt by an office of the Corporation, that office may, in its discretion, refer the claim to the claimant and if the form is returned duly signed and/or certified within three months from the date on which it was so referred, the office may treat the claim as if it had been duly made in the first instance (Regulation 49). The effect of this is that if a claim is originally made, say, in the 11th month from the date on which it becomes due but is resubmitted in the 13th month, it will be treated as if submitted within time, i. e., within 12 months for the purpose of commencement of proceedings before an Employees' Insurance Court under Section 77.

Application before court – time limit

L.3.8. Section 77 requires that an application before an Employees' Insurance Court is to be made within a period of three years from the date on which the cause of action arose. The cause of action in respect of a claim for benefit is not to be deemed to arise unless the insured person or, in the case of dependant's benefit, the dependant(s) of the insured person claims or claim that benefit within a period of twelve months after the claim becomes due or within such further period as the Employees' Insurance Court may allow on grounds which appear to it to be reasonable.

L.3.9. In respect of claims for funeral expenses it has been additionally provided that the claim for such payment has to be made within three months of the date of death of the insured person or within such extended period as the Corporation or any officer or authority authorised by it in this behalf may allow. [Sec. 46(1)(f)].

When claim becomes due

L.3.10. As per Regulation 45, a claim for any benefit under the Act shall, for the purposes of Section 77 of the Act, become due on the following days –

- (a) for sickness benefit or temporary disablement benefit for any period, on the date of issue of the medical certificate in respect of such period: provided that in cases where a person is not entitled to sickness benefit for the first two days of sickness, the due date will be deferred by such days;
- (b) for maternity benefit –

- (i) in case of confinement, on the date of issue, in accordance with these regulations, of certificate of expected confinement or on the day six weeks preceding the expected date of confinement so certified whichever is later or, if no such certificate is issued, on the date of confinement; and
- (ii) in case of miscarriage or in case of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, on the date of issue of the medical certificate of such miscarriage or sickness as the case may be;
- (a) for first payment of disablement benefit for permanent disablement, on the date on which an insured person is declared as permanently disabled in accordance with the Act and the Regulations;
- (b) for first payment of dependants' benefit, on the date of death of insured person in respect of whose death the claim for such benefit arises or, where disablement benefit was payable for that date, on the date following the date of death or, where the beneficiary becomes entitled to claim on any subsequent date, on the date on which he becomes so entitled;
- (c) for subsequent payments of disablement benefit for permanent disablement and for subsequent payments of dependants' benefit, on the last day of the month to which the claim relates; and
- (d) for funeral expenses, on the date of the death of the insured person in respect of whose death the claim for such benefit arises.

Benefit when payable

L.3.11. Regulation 52 of the ESI (General) Regulations, 1950 says as under:

- (1) Any benefit payable under the Act shall be paid –
 - (a) in the case of sickness benefit, not later than 7 days;
 - (b) in the case of funeral expenses not later than 15 days;
 - (c) in the case of the first payment in respect of maternity benefit, not later than 14 days;
 - (d) in the case of the first payment in respect of temporary disablement benefit, not later than one month;
 - (e) in the case of the first payment in respect of permanent disablement benefit, not later than one month, the same time-limit being also applicable for cases of commutation of permanent disablement benefit;
 - (f) in the case of first payment of dependants' benefit not later than 3 months,

after the claim therefor together with the relevant medical or other certificates and any other documentary evidence which may be called for under the regulations has been furnished complete in all particulars to the appropriate office.

- (2) Second and subsequent payments in respect of any maternity, temporary disablement, permanent disablement or dependants' benefit shall be made along with the first payment in respect thereof or within the calendar month following the month to the whole or part of

which they relate, whichever is later, subject to production of any documentary evidence which may be required under the regulations.

- (3) Where a benefit payment is not made within the time limits specified above, it is to be reported to the appropriate Regional Office and has to be made as soon as possible.

Method of payment

L.3.12. As per Regulation 52 (4), benefits under the Act are to be paid in cash at a Branch Office on such days and working hours as may be fixed by the Director General or such other officer of the Corporation, as may be authorised by him from time to time in this behalf, or, at the option of the claimant and, subject to deduction of the cost of remittance, through money order or by any other means which the appropriate office may, in the circumstances of any particular case consider appropriate: provided that the Corporation may waive the deduction of cost of money order remittance from the amount payable in such cases as the Director General may from time to time specify. For the present, such remittance charges are waived and are borne by the Corporation in case of payments of sickness benefit, maternity benefit, temporary disablement benefit, permanent disablement benefit (except the first payment which is not to be made by money order), dependants' benefit (except first payment which is not to be made by money order) and funeral expenses.

Provided further that the Director General may decide that in respect of certain areas/pay offices as may be specified by him from time to time, the payments may be remitted through money order at the cost of the Corporation subject to such restrictions as may be imposed by him from time to time.

L.3.13. As per Regulation 52 (5), where the payment of benefit is to be made at the Branch Office, such office may insist upon the production of the identity card or other document issued in lieu thereof in respect of the insured person.

Authority for certifying eligibility of claimant

L.3.14. The authority which is to certify eligibility of claimants will be the appropriate Branch Office in respect of sickness, maternity, temporary disablement benefits and funeral expenses and the appropriate Regional Office in respect of permanent disablement and dependants' benefits (Reg. 51).

Benefit not assignable or attachable

L.3.15. As per Section 60 of the Act,

- (1) the right to receive any payment of any benefit under this Act shall not be transferable or assignable, and
- (2) no cash benefit payable under this Act shall be liable to attachment or sale in execution of any decree or order of any court.

Bar of benefits under other enactments

L.3.16. As per Section 61 of the Act, when a person is entitled to any of the benefits provided by the ESI Act, he will not be entitled to receive any similar benefit admissible under the provisions of any other enactment.

Persons not to commute cash benefits

L.3.17. Save as may be provided in the regulations, no person will be entitled to commute for a lump sum any periodical payment admissible under the Act (Sec. 62). An insured person whose permanent disablement has been assessed as final and who has been awarded permanent disablement benefit at a rate not exceeding Rs.5/- per day or the commuted value of whose permanent disablement benefit does not exceed Rs.30000/- may apply for commutation of periodical payments of permanent disablement benefit into lump sum (Reg. 76-B). (For details refer to Chapter on Permanent Disablement Benefit Law).

Recipients of SB/TDB to observe conditions

L.3.18. As per Section 64 of the Act, a person who is in receipt of sickness benefit or disablement benefit for temporary disablement –

- (a) shall remain under medical treatment at a dispensary, hospital, clinic or other institution provided under the Act and to carry out the instructions given by the medical officer or medical attendant incharge thereof;
- (b) shall not, while under treatment, do anything which may retard or prejudice his chances of recovery;
- (c) shall not leave the area in which medical treatment provided by the Act is being given, without the permission of the medical officer, medical attendant or such other authority as may be specified in this behalf by the regulations; and
- (d) shall allow himself to be examined by any duly appointed medical officer or other person authorised by the Corporation in this behalf.

L.3.19. Regulation 99 says that sickness benefit or temporary disablement benefit may be suspended if a person who is in receipt of such benefit fails to comply with any of the requirements of Section 64 and such suspension shall be for such number of days as may be decided by the authority authorised by the Director General in this behalf. This authority rests with the appropriate Branch Manager or the Regional Office.

Benefits not to be combined

L.3.20. An insured person shall not be entitled to receive for the same period –

- (a) both sickness benefit and maternity benefit; or
- (b) both sickness benefit and temporary disablement benefit; or
- (c) both maternity benefit and temporary disablement benefit.

Where a person is entitled to more than one type of benefit, he will be entitled to choose which benefit he will receive. In most cases, the benefit payable will be the one which is admissible at a higher rate. An insured person can, however, receive for the same period both sickness benefit and permanent disablement benefit or dependants' benefit. (Section 65).

Repayment of benefit improperly received

L.3.21. Where any person has received any benefit or payment under the Act when he is not lawfully entitled thereto, he will be liable to repay to the Corporation the value of the benefit or the amount of such payment or in case of his death his representative will be liable to repay the same from the assets of the deceased, if any, in his hands. The value of any benefit received other than cash payments is to be

determined by the Medical Commissioner of the Corporation and his decision in this respect will be final. The amount could be recovered as if it were an arrears of land revenue [Section 70 and Sections 45-C to 45-I read with Reg: 96].

Benefit payable upto and including the day of death

L.3.22. If a person dies during the period for which he is entitled to cash benefit under the Act without receiving such payment, the amount of such benefit for the period upto and including the day of his death will be paid to the person nominated by the deceased person in writing in Form-1-his declaration form on record with the Branch Office. If there is no such nomination, the payment would be made to heir or legal representative of the deceased person (Sect. 71).

L.3.23. This section also covers the cases referred to in the context of proviso to sub-rule (2) of Central Rule 56 which states that on the death of an insured woman on delivering a living child, maternity benefit continues to be paid in respect of the living child. The living child thus becomes the person entitled to maternity benefit on its mother's death and, on its own death, it becomes payable to the person nominated by its mother, for the days remaining to be paid at the time of its death.

Change of circumstances to be notified

L.3.24. Every person to whom any benefit is payable under the Act has, as soon as may be practicable, to notify to the appropriate office (Branch Office/Regional Office) of any change of circumstances which he may be expected to know and which might affect the continuance of his right to receipt of such benefit (Reg. 106).

L.3.25. The following example will illustrate the position :-

An insured person dies as a result of employment injury leaving behind a widow who is pregnant at the time of his death and a minor child. The share of dependants' benefit will, in the first instance, be $\frac{3}{5}$ ^{ths} and $\frac{2}{5}$ ^{ths} of the full rate for the widow and the minor child respectively. When the posthumous child is born, a review of the rates of benefit will be necessary and the shares of benefit as redistributed will be $\frac{3}{7}$ ^{ths} for the widow, $\frac{2}{7}$ ^{ths} for the first minor child and $\frac{2}{7}$ ^{ths} for the new-born child. In the above example, the widow shall, as soon as practicable, notify the appropriate office regarding the birth of the child as this affects the rates of benefit payable to her as well as to the first minor child. Similarly, if a widow remarries or if a minor female dependant marries, the fact of remarriage, marriage, etc., should be intimated to the appropriate office as soon as possible.

Claimant minor or insane

L.3.26(1). In case the claimant is a minor, the benefit is payable to his legal guardian. The claim form will be completed by the legal guardian on behalf of the minor and the payment of the benefit will be made to the legal guardian on behalf of the minor.

(2) In case the insured person is a lunatic, payment will be made as detailed in the procedural part of this Chapter [Paras P.3.83 to P.3.85].

Employer not to reduce wages, etc.

L.3.27. Section 72 of this Act says that no employer by reason only of his liability for any contribution payable under the Act, shall directly or indirectly reduce the wages of any employee or, except as provided by the regulations, discontinue or reduce benefits payable to him under the conditions of his service which are similar to the benefits conferred by the Act.

L.3.28. Regulation 97 provides the exceptions envisaged in Section 72. It says that an employer may discontinue or reduce the benefits payable to his employees under conditions of their service which are similar to the benefits conferred by the Act to the extent specified below:

- (a) From the date of commencement of the first benefit period following 'A-Day' for his factory or establishment –
 - (i) sick leave on half pay to the full extent;
 - (ii) such proportion of any combined general purposes and sick leave on half pay as may be assigned as sick leave but in any case not exceeding 50% of such combined leave;
- (b) Any maternity benefit granted to women employees to the extent to which such women employees may become entitled to maternity benefit under the Act:

Provided that where an employee avails himself of any leave from the employer for sickness, maternity or temporary disablement, the employer will be entitled to deduct from the leave salary of the employee the amount of benefit to which he/she may be entitled under the Act for the corresponding period.

L.3.29. It is clarified that before the employer can deduct any amount of sickness benefit/temporary disablement benefit/maternity benefit from the leave salary of any employee, it is necessary that the claimant should actually have received the benefit from the Corporation. The Corporation (the appropriate Branch Office), on request from the employer, will inform him about the amount of sickness benefit/temporary disablement benefit/maternity benefit paid to the employee for the period of such authorised leave as may have been availed by the insured person. Please also see in this connection para L.3.30.5 below.

When persons not entitled to receive benefit

L.3.30.1. Section 63 as amended in 1989, and which became effective from 20-10-1989, states as under:-

Persons not entitled to receive benefit in certain cases.

63. Save as may be provided in the regulations, no person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he works or remains on leave or on a holiday in respect of which he receives wages or on any day on which he remains on strike.

L.3.30.2. Regulation 99A provided as a logical follow up of the above-noted amendment to Section 63, provides as under:

Sickness or temporary disablement benefit during strike.

99A. No person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he remains on strike except in the following circumstances :

- (i) If a person is receiving medical treatment and attendance as an indoor patient in any Employees' State Insurance Hospital or a hospital recognised by the Employees' State Insurance Corporation for such treatment; or
- (ii) If a person is entitled to receive extended sickness benefit for any of the diseases for which such benefit is admissible; or

- (iii) If a person is in receipt of sickness benefit or disablement benefit for temporary disablement immediately preceding the date of commencement of notice of the strike given by the employees' union(s) to the management of the factory/establishment.
- (iv) If an insured person/insured woman has undergone operation on account of vasectomy/tubectomy, he/she shall be entitled to enhanced sickness benefit on any day on which he/she remains on leave during the period of strike or remains on leave, or on holiday for which he/she receives wages.

L.3.30.3. Thus, the exception provided in regulation 99A is in respect of the period of strike only. An IP who receives leave wages for any day or wages for a holiday from his employer during the period of his sickness or temporary disablement is absolutely not entitled to either sickness benefit (including extended sickness benefit) or temporary disablement benefit for either of these days.

L.3.30.4. But, an insured person/insured woman undergoing vasectomy/tubectomy can receive leave wages or holiday wages from his/her employer, in addition to receiving enhanced sickness benefit from the Corporation and even when he/she is on strike.

L.3.30.5. In the light of provisions of Section 63, as amended, proviso to regulation 97 quoted above, has perhaps become largely redundant or atleast inoperative.

Security of service during sickness, etc.

L.3.31. Section 73 of the Act says as under:

- (1) No employer shall dismiss, discharge, or reduce or otherwise punish an employee during the period the employee is in receipt of sickness benefit or maternity benefit, nor shall he, except as provided under the regulations, dismiss, discharge, or reduce or otherwise punish an employee during the period he is in receipt of disablement benefit for temporary disablement or is under medical treatment for sickness or is absent from work as a result of illness duly certified in accordance with the regulations to arise out of pregnancy or confinement rendering the employee unfit for work.
- (2) No notice of dismissal or discharge or reduction given to an employee during the period specified in sub-section (1) above shall be valid or operative.

L.3.32. Regulation 98 provides that if the conditions of service of an employee so allow, an employer may discharge or reduce on due notice an employee after (i) he/she has been in receipt of temporary disablement benefit for a continuous period of six months or more or (ii) he/she has been under medical treatment for sickness or she has been absent from work as a result of sickness arising out of pregnancy or confinement for a continuous period of six months or more (iii) he/she has under medical treatment for any of the long-term diseases for a continuous period of 18 months or more. The list of long term diseases may be seen in Chapter VIII – Law.

Adjudication of disputes and claims

L.3.33. Under Section 74 of the Act, the State Government constitutes an Employees' Insurance Court by notification in the official gazette for adjudication of disputes and claims for such local areas as that government may specify. The Employees' Insurance Court is empowered under Section 75 to decide, in accordance with the provisions of the Act, any question or dispute as to –

- (a) whether any person is an employee within the meaning of the Act or whether he is liable to pay the employees' contribution, or
- (b) the rate of wages or average daily wages of an employee for the purposes of the Act, or

- (c) the rate of contribution payable by a principal employer in respect of any employee, or
- (d) the person who is or was the principal employer in respect of any employee, or
- (e) the right of any person to any benefit and as to the amount and duration thereof, or
- (f) any direction issued by the Corporation under Section 55-A on a review of any payment of dependants' benefit, or
- (g) any other matter which is in dispute between a principal employer and the Corporation, or between a principal employer and an immediate employer or between a person and the Corporation or between an employee and a principal or immediate employer, in respect of any contribution or benefit or other dues payable or recoverable under the Act, or any other matter required to be or which may be decided by the Employees' Insurance Court under the Act.

L.3.34. The Employees' Insurance Court is also empowered to decide the following claims, namely: -

- (a) Claim for the recovery of contributions from the principal employer.
- (b) Claim by a principal employer to recover contributions from any immediate employer.
- (c) Claim against a principal employer under Section 68.
- (d) Claim under Section 70 for the recovery of the value or amount of the benefits improperly received by a person when he is not lawfully entitled thereto; and
- (e) Any claim for the recovery of any benefit admissible under the Act.

L.3.35. *Vide* sub-section (2A) of Section 75 *ibid*, if in any proceedings before the Employees' Insurance Court a disablement question arises and the decision of a medical board or a medical appeal tribunal has not been obtained on the same and the decision of such question is necessary for the determination of the claim or question before the Employees' Insurance Court, that court shall direct the Corporation to have the question decided by the Act and shall thereafter proceed with the determination of the claim or question before it in accordance with the decision of the medical board or the medical appeal tribunal, as the case may be, except where an appeal has been filed before the Employees' Insurance Court under Sub-section (2) of Section 54A in which case the Employees' Insurance Court may itself determine all the issues arising before it.

L.3.36. No civil court shall have jurisdiction to decide or deal with any question or dispute as aforesaid or to adjudicate on any liability which by or under the Act is to be decided by a medical board, or by a medical appeal tribunal or by the Employees' Insurance Court [Sub-Section (3) of Section 75].

Institution of proceedings

L.3.37. Section 76 of the Act says inter-alia as under:

- (1) All proceedings before the Employees' Insurance Court shall be instituted in the Court appointed for the local area in which the insured person was working at the time the question or dispute arose.
- (2) If the court is satisfied that any matter arising out of any proceedings pending before it can be more conveniently dealt with by any other Employees' Insurance Court in the same State, it may, subject to any rules made by the State Government in this behalf, order such matter to be transferred to such other Court for disposal and shall forthwith transmit to such other Court the records connected with that matter.

- (3) The State Government may transfer any matter pending before any Employees' Insurance Court in the State to any such Court in another State with the consent of the Government of that State.
- (4) The Court to which any matter is transferred under sub-section (2) or sub-section (3) shall continue the proceedings as if they had been originally instituted in it.

Appeal

L.3.38. Section 82 of the Act says as under :-

- (1) Save as expressly provided in this Section, no appeal shall lie from an order of an Employees' Insurance Court.
- (2) An appeal shall lie to the High Court from an order of an Employees' Insurance Court if it involves a substantial question of law.
- (3) The period of limitation for an appeal under this section shall be sixty days.
- (4) The provisions of Section 5 and 12 of the Limitation Act, 1963, shall apply to appeals under this section.

Punishment for false statement

L.3.39. Section 84 of the Act (as amended) says that whoever, for the purpose of causing any increase in payment or benefit under the Act, or for the purpose of causing any payment or benefit to be made where no payment or benefit is authorised by or under the Act, or for the purpose of avoiding any payment to be made by himself under the Act, or enabling any other person to avoid any such payment, knowingly makes or causes to be made any false statement or false representation, shall be punishable with imprisonment for a term which may extend to six months, or with fine not exceeding two thousand rupees or with both:

Provided that where an insured person is convicted under this section, he shall not be entitled for any cash benefit under this Act for such period as may be prescribed by the Central Government.

L.3.40. Rule 62 of the Central Rules provides for dis-entitlement of insured person referred to in proviso above-quoted. The said Rule is reproduced below :-

Bar on grant of cash benefits. 62. Where an insured person is convicted under Section 84 of the Act he shall not be entitled to any cash benefit admissible under the Act for a period of three months for first conviction and six months for each subsequent conviction from the date of receipt of judgement of the Court in the concerned office of the Corporation.

Prosecutions

L.3.41. Section 86 as amended says as under :

- (1) No prosecution under the Act shall be instituted except by or with the previous sanction of the Insurance Commissioner or of such other officer of the Corporation as may be authorised in this behalf by the Director General of the Corporation (The Regional Directors have been authorised to sanction prosecutions).
- (2) No court inferior to that of a Metropolitan Magistrate or Judicial Magistrate of the First Class shall try any offence under the Act.
- (3) No Court shall take cognisance of any offence under the Act except on a complaint made in writing in respect thereof. (The limitation period of 6 months has been omitted with effect from 20.10.1989).

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CHAPTER III

GENERAL CLAIMS PROCEDURE

Claim for sickness benefit and temporary disablement benefit

P.3.1. Every person claiming any benefit provided under the Act has to submit a claim in writing along with an appropriate certificate issued by an authority specified under the Regulations. Detailed instructions regarding acceptance of such certificates are contained in Chapter II – Certification.

P.3.2. All certificates, whether received by post or cleared from the box, or delivered personally by the insured person or his agent, should be stamped by the receptionist with a stamp having name of the Branch Office and date of receipt, as soon as they are received. The certificates cleared from the box should be stamped with reference to the last clearance from the box. As far as possible the certificates should be collected from the box daily at a fixed hour.

P.3.3. All the certificates received from insured persons should be examined in the first instance by the receptionist/claims clerk. In case any obvious defects are noticed in any certificate, for example, omission of date of issue or signature of the IMO/IMP or of disease, or some unattested correction, the certificate should be sent back to the IMO/IMP concerned for corrections or for completion of omissions, etc. with a covering letter, pointing out the discrepancies.

P.3.4. Where the discrepancies or defects are of a very minor nature and do not affect the right of insured person to benefit, these may be got corrected by the receptionist/claims clerk from the Manager under his dated signatures and these certificates need not be referred back. The intention is that no time should be lost in getting the necessary corrections carried out as soon as possible so that payment of cash benefit can be arranged early.

P.3.5. In doubtful cases the receptionist/claims clerk should also –

- (a) compare the signature and rubber stamp of the IMO/IMP on certificate with the specimen of his signatures and stamp kept at the Branch Office. The Regional Office will arrange for providing specimen signatures of the IMOs/IMPs from the Administrative Medical Officer to the Branch Office;
- (b) examine the form of certificate with reference to its approved specifications, e.g., its size, design, colour, book number and certificate number, perforation and imprint line. In case of any difference, he should immediately bring the same to the notice of the Manager who may, if the differences are material, make such further enquiries as he may consider necessary and then report the matter to the Regional Director.

Certificate without insurance number

P.3.6 In case an insured person presents a certificate without an insurance number, the receptionist/claims clerk should note on the certificate insured person's department, token, shift etc. and ascertain from the employer his insurance number or serial number on the return of declaration forms and date of its submission to the Branch Office.

Opening of ledger sheet

P.3.7. Ledger sheet shall be opened at Branch Office. If, however, the insured person belongs to another Branch Office, the Regional Office will send the relevant documents to that Branch Office under advice to this Branch Office which will then forward the certificates of the insured person to the Branch Office concerned.

Payment of TDB in absence of ledger sheet

P.3.8. Where, for any reason, the ledger sheet is not received or is not likely to be received from the Regional Office within reasonable time, and the Branch Office is satisfied that further delay is likely to cause hardship to the insured person, the claim for temporary disablement benefit may be processed in the following manner :-

- (a) The Branch Office may open an ordinary register for the purpose with the same columns as in a ledger sheet by inserting a fly-leaf and arrange payment of temporary disablement benefit after recording entries in this register.
- (b) As soon as the ledger sheet of the insured person is received, the entries should be transferred from the register to the ledger sheet under Manager's signatures and further payments should be recorded on the ledger sheet.
- (c) The relevant page in the register should be closed with entries "Transferred to ledger sheet, *vide* ledger No..... folio No....." and "No further payment" under the dated initials of Manager.
- (d) The register should be preserved for local audit and external audit purposes.

Duplicate ledger sheet

P.3.9. Chances of loss of a ledger sheet under the ledger system are extremely rare. However, if a case of loss of a ledger sheet does occur, it will immediately point to the possibility of a *mala fide* removal of the sheet. The Branch Manager must personally ensure that formalities of calling of abstention/certification particulars in forms ESIC-88 and ESIC-89 during the previous plus the current benefit period from the employer and the Insurance Medical Officer are strictly observed before opening a duplicate ledger sheet. ESIC-91 should also be invariably obtained from the insured person. An entry regarding opening of the duplicate ledger sheet must also be made in the master register and the declaration form. Specimen copies of form ESIC-88, 89, 90, 91 may be found at Annexure I, II, III and IV respectively.

Completion of claim form and entry in claims diary

P.3.10. The receptionist/claims clerk will generally receive two types of certificates, i. e., the first certificate and/or the subsequent certificate. The first certificate will be dealt with as follows :-

- (a) If the first certificate is brought personally by the claimant and the claim on form 9 has not been completed or has been incorrectly completed, the receptionist/claims clerk will assist the claimant in completing or correcting it. The claimant will be advised to call again with the subsequent certificate when payment, if due, will be made.
- (b) If the first certificate is brought by the claimant's agent or messenger, and the claim on form 9 has not been completed or has been incorrectly completed, the agent or the messenger will be asked to get the form correctly filled in by the claimant. For this, the claims clerk would give the blank claim form 9 to the claimant's agent or messenger for completion by the claimant by striking off portions in the claim form not relevant to the certificate in question.
- (c) The receptionist/claims clerk should diarise every certificate and indicate the date and diary number on it.
- (d) All first as well as subsequent certificates including those pertaining to maternity benefit received in the Branch Office should be diarised in a single claims diary in form ESIC-12, as per specimen below :-

ESIC-12

EMPLOYEES' STATE INSURANCE CORPORATION

CLAIMS DIARY

.....Branch Office
Year.....

Month.....

Sl. No.	Date of issue	Ins. No.	Kind of certificate
(1)	(2)	(3)	(4)

Sl. No.	Date of issue	Ins. No.	Kind of certificate
(1)	(2)	(3)	(4)

Entries on each day to be opened with the date at the top

- (e) The receptionist/claims clerk should thereafter hand-over the first certificate to the dealing clerk responsible for maintenance of returns of contributions for calculation of benefit rate, except in small offices where he himself has to do it.
- (f) The rate clerk will ascertain the rate and make entries in the documents in accordance with the procedure.

Maintenance of claims diary

P.3.11.1. Everyday at the start of business in the Branch Office the person maintaining the claims diary in ESIC-12 would enter and underline the date, month and year in red ink in the middle of its columns just below the last entry made on the previous working day. He will then enter all certificates received in ascending serial order and fill in columns 1 to 4 of this diary. A new serial number is to be given at the beginning of every month to continue until the end of the month. Column 4 of ESIC-12 should indicate the types of the certificates. More than one diary may be opened in the Branch Office depending on the volume of work and keeping in view the convenience of the insured persons. This diary should be in foolscap size and of the same quality of paper as ESIC-39.

P.3.11.2. At the end of each day the Manager/Head Clerk will draw a line after the last entry and put his initials below so as to prevent any fraudulent insertions on a later date.

Standard benefit rate

P.3.12. As the certificates are received, these will be passed on to the rate clerk who will prepare standard benefit rate on each first certificate from the RC for the relevant contribution period. For this, he will note the amount of total wages and the number of days for which wages paid/payable respectively against his name on the first certificate and indicate the same as a fraction, e.g. thus:12595/183. He will then ascertain the daily standard benefit rate from the ready-reckoner provided and write it down opposite to this fraction and join the two by an arrow mark and record his dated initials below the entry. He will also enter it against the relevant entry in the RC in the remarks column and initial it. He will pass on the first certificate and the bundle of RC to the checker. Cent per cent rates will be checked by the checker who would also put his initials below the initials of rate clerk on the first certificate as also on the return of contributions. The first certificate will then be filed in the pending run in insurance number order.

P.3.13.1. Ten per cent of the rates thus prepared would also be checked by the Manager who must take the important precaution of checking the rates from the copy of the return of contributions retained by him in his personal custody and not from the return used by the rate clerk. The Manager will also put his initials on the first certificate for having counter-checked the rates. The rates to be checked by him will be selected at random and without giving any hint or indication to the staff below.

P.3.13.2. Care must also be taken to see that the figures in columns 4 & 5 have not been altered. If the claims clerk or checker comes across any such unattested cutting or overwriting in either the amount or the days he should bring the same immediately to the notice of the Manager. The Manager will compare the figures under scrutiny with those in the copy of RC in his custody and decide on further action depending on his findings. If the alterations appear fraudulent he will get the actual wage-cum-contribution record checked with the employer's record and report the matter to Regional Office.

P.3.14.1. When the insured person visits the Branch Office for claiming benefit, the claims clerk will record the daily rate of benefit in the ledger as follows:

- (a) 20% more than the standard benefit rate if the claim is for sickness benefit;
- (b) 50% more than the standard benefit rate if the claim is for temporary disablement benefit.

This entry will be intialled by him and attested by the checker when the ledger goes to him for checking. The Manager should also countercheck and initial the posting of SB/TDB rate in the column "Checked by" while checking the percentage of rates prescribed for him.

P.3.14.2. When rate clerk finds from the RC that the rate has already been prepared, he will enter the letter 'R' on the first certificate and initial the entry and place it back in the pending run of first certificates.

P.3.14.3. When employer's code number is not given by the IMO on a first certificate, the matter will be brought to the notice of the Manager. In such a case, it will be unavoidable to await the insured person in Branch Office.

P.3.14.4. As an alternative to the procedure outlined above, the standard benefit rate as well as rates of sickness benefit / temporary disablement benefit can be directly determined from the average daily wages as recorded by the employer in column 7 of the RC. A ready reckoner table for this purpose is at Annexure IVA. The daily rates of these benefits can be determined / checked/ attested as per procedure in the foregoing paras, with the help of this table. However, in order to ensure infallible accuracy of these rates, it will have to be ensured that the average daily wages (figures in col 5 of RC / divided by those in column 4) have been accurately calculated by the employer in each case (up to 2 places of decimal without rounding off.). In fact, the procedure detailed herein has already been adopted in some regions.

P.3.14.5 With the insertion of Rule 51A to the ESI (Central) Rules, the benefit provisions of the Act have been extended to the disabled persons drawing remuneration not exceeding Rs.25000/- per month, w.e.f. 1st April 2008. A ready reckoner of daily standard benefit rates, sickness benefit rates and TDB rates for disabled persons drawing wages between Rs.10000/- and Rs.25000/- pm may be seen in continuation in Annexure IVA.

Benefit rates where factory/estt. is closed

P.3.15. If a factory/estt. is closed or is under liquidation and the return of contributions is not received and contributory record cannot at all be obtained from the employer, the following procedure may be adopted to settle the claims pending for a benefit period in respect of such a closed factory/estt.:

- (i) Eligibility and benefit rate should be ascertained from wage-cum-contribution records available at the Regional Office/Branch Office. For this purpose, return of contribution (form 6) for the immediately preceding contribution period, if any, may be deemed to be one that is applicable for the benefit period under consideration. For example, for determining standard benefit rate for sickness occurring during the benefit period say from 1.7.09 to 31.12.09, the wage-cum-contribution record for the contribution period ended 31.3.09 is required but since the same is not available, the wage-cum contribution record for the contribution period ended 30.9.2008 may be consulted for the purpose and eligibility and rate be determined on that basis.
- (ii) If no such wage-cum-contribution record for the contribution period ending on 30.9.2008 (in the above example) is available, the same having been weeded out or otherwise, and the persons had drawn sickness benefit during the immediately preceding benefit period, i. e., during the benefit period 1.7.2008 to 31.12.2008, the rate of benefit shall be one that is applicable for the said benefit period.
- (iii) In case the above procedure cannot be followed, the eligibility and benefit rates may be worked out on the basis of declaration of the insured person that he had been a regular employee during the contribution period corresponding to the benefit period under consideration and that he had received wages amounting to Rs..... and that necessary contributions were regularly deducted from his wages during the said contribution period, that he claims benefit accordingly and undertakes the liability of legal action under Section 84 of the Employees' State Insurance Act and to refund excess amount, if any, if his statement is found to be incorrect. He must also provide details of wages received during the wage periods falling within the contribution period and the number of days for which these wages were paid to him. Collateral evidence such as the rate of contribution, rate of benefit in the previous contribution/benefit period may be secured to assess the correctness of his statement. The insured person should also indicate the name of the employer, the day or month and year of commencement of his employment and last day of working/discharge etc. The statement of the insured person should also be checked, where possible, with available records. A standard form of statement may be devised for this purpose and a copy of the declaration may be kept on record.

It may also be emphasised, however, that as some payments are likely to be of substantial amounts (ESB, PDB, DB), it is advisable not to depend merely on the statement of the insured person and no effort should be spared to get the correct information.

P.3.16. In order to have a check over the payment of temporary disablement benefit and to limit the duration for which temporary disablement benefit is payable, BM should refer such a category of TDB cases to the Medical Referee atleast every fortnight through incapacity references except in case of fractures etc., which necessarily involve a long period of incapacity.

P.3.17 Cases of permanent disablement benefit, commutation and dependants' benefit will, in any case, continue to be referred to Headquarters Office when rates are calculated as per para P.3.15.

P.3.18. It is further made clear that these "rates" may be treated as "provisional" with the hope that the factory/estt. might re-start and records may be made available.

P.3.19. Since such payments are not in accordance with the provisions of the regular instructions, full details thereof as in the proforma given below should be sent to Headquarters through the Regional Director for *ex-post-facto* approval and regularisation of these payments by the Insurance Commissioner. The grand total of the amount paid, employer-wise and benefit-wise (i. e. sickness benefit, temporary disablement benefit and so on) may also be specifically indicated.

P.3.20. Necessary register/record for the purpose may be maintained to facilitate sending the desired details of such payments to Headquarters six-monthly. The statement for the six monthly periods January to June and July to December will be kept in the Regional Office for a further period of 6 months to watch the position of re-opening of the factory/estt. and verification of such cases by the Deputy Director (Finance) at the Regional Office. After the expiry of this additional period of 6 months, the statement will be sent to the Hqrs. office within a period of 45 days. Where no such case is involved a 'nil' statement should be sent. The Branch Offices, in turn, have to send the statement to the Regional Office in time and as directed. A proforma for this statement is given below:

Statement of payments made on the basis of ESIC-71/Declaration of insured persons where the factory(ies)/establishment(s) is/are closed down or is/are under provisional liquidation for the half year ending

1. Name of factory/establishment :
2. Code number :
3. Date of closure :
4. Whether factory/establishment is under provisional liquidation :
5. Whether factory/establishment has restarted functioning :
6. If so, date :

Particulars of insured persons paid benefits during the six monthly period from.....

Sl. No.	Name of I. P.	Ins. No.	Nature of Benefit	Period of claim	Rate of benefit	Basis of payment	Amount paid	Remarks
1	2	3	4	5	6	7	8	9

Grand Total.....

(Certificate of the efforts made by Manager for verification or ESIC-71/or declaration of insured persons alongwith reasons responsible for non-verification of the said particulars, if any, must be furnished.)

Manager
Branch Office.....

To

The Regional Director, Regional Office,

P.3.21 Apart from the aforesaid statement, every Branch Office has to submit another statement referred to in para P.7.47. Hqs. have decided that while the Branch Office will continue to send as before the aforesaid statement as described in the preceding para as well as in para P.7.47, the Regional Office will submit to Hqs. a single statement combining all the information in it, in respect of all the Branch Offices in the Region, in form given below:-

HALF YEARLY STATEMENT OF PAYMENTS MADE ON THE BASIS OF ESIC – 71 / DECLARATION OF IPs WHERE FACTORY / ESTT. IS CLOSED AND EVEN ESIC – 71 IS NOT RECEIVED. – CASES OF WRONG PAYMENTS ETC.- HALF YEAR ENDED _____

Cases pending in the beginning of half year (benefit period wise)	ESIC 71s issued during the half year	Total	No. of ESIC 71s verified	Balance	No. of cases of wrong payments detected as per proforma B received from the Branch Offices.	Whether appropriate action taken in Regional Office in such cases or not
1	2	3	4	5	6	7

If not, reasons therefor	No. of cases where payments made on declarations of IPs (normally benefit is not paid on the basis of declaration. Please refer paras P.3.15 to P.3.20 above)				Remarks
8	9				10
	Name & Ins No. of IP	Amount of benefit paid	Name & code no. of employer	Date of restart of factory if so started.	

Action on subsequent certificate

P.3.22. When the subsequent certificate is brought personally by the claimant, the receptionist, after diarising the certificate, shall assist the claimant in filling in claim. If necessary, he will direct the claimant to the claims clerk concerned. In case subsequent certificate is received otherwise, he will diarise the certificate and forward it to the claims clerk concerned. In offices where a receptionist is not provided, the claims clerk will himself complete all the operations. Where claim or certificate is received by post or through box, the claims clerk will put the certificate in relevant folder in insurance number order. He should also issue ESIC-34 to the insured person for collecting benefit in case the benefit provisions of the Scheme have been in operation for less than 3 years, which period is considered sufficient for the insured persons to get acquainted with their rights and obligations. Where, however, the claim form is complete and accompanied with a request that payment may be made by money order or where insured person has personally come with subsequent certificate to get payment, the claims clerk, after diarising the claim, will take further action on the claim. In cases where first certificate has been received and no other subsequent certificate has been received or the claim received is defective, a letter in form ESIC-55 should be sent to the insured person pointing out the requirements. ESIC-55 need not, however, be issued in centres where

the benefit provisions have been in force for more than 3 years for reasons similar to those in respect of ESIC-34 as stated above.

Steps to establish IP/IW's identity

P.3.23. When IP visits the Branch Office for the first time, his/her correct and infallible identity has to be established in the first instance. For this, the following steps will be necessary : -

- (i) The permanent identity card (PIC) of the IP must have a photograph of himself and his family and he can be identified from such a photograph as the genuine holder of his PIC.
- (ii) His/her permanent identity card (PIC) bears his/her signatures/clear thumb impression
- (iii) The PIC bears the identification marks of the IP/IW as recorded by the IMO/IMP; if not, IP/IW should be directed to get the same done without which it may be made clear to him/her that payment of cash benefit cannot be made to him/her.
- (iv) IP's/IW's signatures/TI should be obtained on the ledger sheet. The thumb impression should be taken in pad ink and the lines on his/her thumb should be clearly distinguishable. A smudged thumb impression will be useless.
- (v) If an IP/IW is unable to make his/her visit to the Branch Office due to serious illness or for fracture lower extremity, Manager should arrange to send the ledger sheet to his/her home alongwith benefit payment docket and cash benefit (if within cash payment limits laid down). The official visiting the IP's residence should fully satisfy himself about the correct identity of IP/IW at the time of payment and obtain his/her signatures/TI on the docket as well as the ledger page.
- (vi) In case where the P.I.Cs. are prepared manullay the Regional Office supplies plastic covers for PICs. But if supplies fall short, Branch Office has to send PICs without the plastic covers and in that event, a few IPs get their PICs laminated. Such laminated PICs should not be accepted if the same is without IP's/IW's signatures and identification marks. But, to avoid hardship to the IP/IW, if found genuine, he/she will be advised to obtain a duplicate PIC, procedure for which has been laid down in Chapter I-Registration.
- (vii) Those IPs to whom a PIC has not been issued, will be normally having a temporary identification certificate (TIC). As a rule, this category will include those persons who may have met with an accident during the first three months after their employment and are certified as suffering from temporary disablement. Such persons can also be identified with sufficient certainty by comparing the visible injury mark with the entries of location of injury reported in the accident report and B. I. 1.

Preparation of claim papers

P.3.24. When the IP/TW visits the Branch Office, the claims clerk, after checking his/her identity will get the claim filled in and signed for the relevant cash benefit admissible as well as scrutinize the certificate in support of the claim and consider if an incapacity reference is due. If Manager's prior decision is required on any point, e.g., on delayed submission of certificates, the papers will be submitted first to him and processed after obtaining his decision.

Completion of benefit documents

P.3.25. If the claims clerk finds that benefit is payable for all or some of the days covered by the certificate, he should prepare benefit payment docket and slip by using a double sided carbon paper compulsorily and fill up the relevant columns of the ledger sheet. (Instructions regarding completion of specific entries in the ledger sheet in case of different types of benefits are contained in the relevant chapter dealing with that benefit). He will then cancel all the documents on which payment is involved with a rubber stamp "CANCELLED", in block capitals to avoid chances of duplicate payment on the basis of such documents. He will then pass on the ledger alongwith relevant documents to the checker for checking. The claim is thereafter passed by the Manager and sent to the Cashier for making payment. The checker and Manager, while checking and passing the claim, should also put their dated initials against relevant columns of the ledger sheet.

P.3.25A. It is emphasised that preparation of benefit payment slip and its handing over to the beneficiary is absolutely essential and this should never be dispensed with under any circumstances. Officers of the Regional Office, during their visit to a Branch Office, should ascertain from the beneficiaries concerned whether they are receiving the benefits in full and whether the Branch Office is issuing the payment slips to them.

P.3.26. Normally only one docket should be prepared on a single day in respect of an IP. But more than one docket can be prepared in the following cases:

1. Where the insured person is to be paid partly sickness benefit and partly extended sickness benefit.
2. Where the insured person claims payment for more than one benefit, i. e., sickness benefit and temporary disablement benefit or maternity benefit, etc.
3. Where the rate of benefit differs due to change of benefit period.

Rounding off of benefit payment

P.3.27. Aggregate amount of each docket should be rounded off to next higher rupee, i. e., any fraction of rupee should be rounded off to the next higher rupee. This should also be done for benefit payments sent through money order.

Action where benefit not admissible-regret slip

P.3.28. Where benefit is not payable to an insured person, a regret slip in form ESIC-15 indicating the reason for non-payment applicable in the case should be prepared and given to the insured person on demand, if he is not satisfied with verbal clarification of the position. At the same time the claims clerk/counter clerk should affix rubber stamp "Not Payable" on all the claim papers and relevant documents and also put his dated initials on each.

Every effort should be made to see that an insured person who is not entitled to any payment is not required to stay in the Branch Office longer than what may be absolutely necessary and that he is informed about his claim without delay.

Claims received through agent

P.3.29. Where the claim is brought by the agent of the insured person, he will have with him (a) the identity card of the insured person (b) a letter of authority and (c) a receipt for the amount payable to the insured person. The letter of authority will be submitted to the claims clerk, who will attach it to the claim. The claims clerk will then examine the identity of the insured person by comparing his name, address, Ins. No., and signature, if possible on the claim with the particulars on the identity card. He will then see if the claim form and certificate are complete in all respects. He will also examine the claimant's signature and other particulars on the letter of authority and the receipt to see if they are in order. If they are incomplete, the agent will be advised to get them completed by the insured person and the consideration of the claim will have to be postponed till their submission after completion. At the same time the agent should also be advised about the facilities available to insured person for payment of benefit through money order free of any charges and the claimant, if he so desired, could also avail in the particular case.

P.3.30. If the claim is otherwise in order, the claims clerk will verify the identity of the agent. He will see whether the agent is literate and can be identified by his signature on the letter of authority or whether he is himself an insured person and can be identified by his identity card. If his identification is possible, the claims clerk will proceed with the claim. If identification of agent is not possible, the payment will not be made to him and he will be advised to ask the insured person to come personally or to send his request to make the payment by money order. On receipt of his request, the payment will be made by money order, as described in paras P.3.33 below. In every case, the Branch Office will be well-advised not to encourage the mode of payment through agent.

Payment by money order

P.3.31. Proviso to sub-Regulation (4) of Regulation 52 of ESI (General) Regulations 1950 states that the Corporation may waive the deduction of the cost of money order remittance in such cases as the Director General may, from time to time, specify. At its meeting held on 22.8.68, the Standing Committee approved that the payment of cash benefits may be made to the insured persons by money order at the Corporation's cost irrespective of the amount of benefit to be remitted. The Director General decided that all payments except first payment of permanent (partial and total) disablement benefit and of dependants' benefit, irrespective of the amount, may be paid by money order, at the cost of the Corporation provided that there is a request by the payee for payment by money order.

P.3.32.1. The Corporation, at its meeting held on 22.3.69, authorised the Director General to decide for payment of benefit by money order at the cost of Corporation even without the request of the insured persons in respect of certain areas/pay offices as may be specified by him from time to time. The Regional Director/Branch Manager (through Regional Office) can make a reference to Headquarters with full details in case he desires payment through money order without any specific request from insured persons of any particular area/pay office, for the decision of the Director General.

P.3.32.2. The Standing Committee at its meeting held on 17.2.80 extended the facility of remittance of funeral expenses also by money order at the cost of the Corporation.

P.3.32.3. The first payment of permanent disablement benefit and dependants' benefit cannot be made by money order even at the cost of the beneficiary himself and it must be made invariably at the Branch Office on personal appearance of the claimant. The object is that the Branch Office has to satisfy itself about the identity of the person claiming life pension. For the aforesaid reason it will not be correct to send the commuted value of permanent disablement benefit by money order.

P.3.32.4. If, however, a beneficiary in receipt of permanent disablement benefit and dependants' benefit moves away to his village or to another town, his records should be transferred to the Branch Office nearest to his village or town and the payment of his long-term benefit will continue from that Branch Office in accordance with the existing instructions on the subject. In case a beneficiary goes to his village

etc. before the receipt of first payment of permanent disablement benefit or dependants' benefit, the first payment may be made to him at the Branch Office nearest to his village etc. but in no case by money order.

P.3.32.5. There may be a certain severely disabled person who will find it difficult to travel even the short distance from his village to the nearest Branch Office. Where the disablement is substantial, say 50% or more, an official from the nearest Branch Office may visit the person at his residence and make payment.

Money order payment procedure

P.3.33. The procedure for payment of benefits by money order is detailed below :

- (i) Normally a request for payment by money order will be made by the insured person/beneficiary on the claim form itself. Sometimes, a request for payment by money order is also received through a separate letter. In each case, the claims clerk will compare signature/thumb impression given on the claim and/or letter with those recorded in the ledger sheet/dependants'/permanent disablement benefit register in order to establish the claimant's identity. If the claim is payable, he will prepare a docket in form ESIC-16A, fill in the money order form and enter particulars of the payment on the money order coupon (bottom) giving details of the payment. A rubber stamp of suitable size so as to be accommodated within the space available in the money order coupon containing the following matter may be used and blank space filled in to serve as benefit payment slip.

The payment represents.....
benefit fordays from to
@Rs..... per day amounting to Rs. waiting days:.....

Manager

However, in case there are defects in the claim, the Branch Office should inform the insured person about the same and payment may be arranged when the defects are removed.

- (ii-a) The claim and money order will be checked by checker, and passed on to Manager who, after applying the necessary checks, will record a pay order on each benefit payment docket, sign on the money order form at the appropriate place and initial in the appropriate column in each ledger sheet. The Manager will then pass on all the papers to the Cashier.
- (ii-b) The Cashier will prepare a schedule sheet and enter the serial number given in schedule sheet and the benefit payment docket on the payee's acknowledgement portion of the money order, make entries in the ledger sheet, prepare a crossed cheque in favour of the Post Master for the total amount to be remitted by money order including money order commission in respect of payments for which money order commission is to be borne by the Corporation.
- (ii-c) In rare cases, however, e. g., where the BM is not available to sign the cheque, or for some other unavoidable reason, amount of money orders and money order commission may be sent in cash to the post office. In case the amount to be sent to the post office is upto Rs. 1000/- a peon may be sent to the post office and for amount in excess of Rs. 1000/- the cashier should himself go to the post office.
- (ii-d) When amount of money orders has to be sent to the post office in cash, the BM should certify in the schedule sheet that the money orders have been actually despatched and the postal receipts are held by him.

- (iii) The postal receipts received from the post office should be pasted with the payment dockets. But the acknowledgements when received from payees need not be pasted with the dockets and may be kept separately in a folder in the same serial order in which the dockets are arranged. This will enable the two to be easily connected at any time.
- (iv) When the payee's acknowledgement of a payment sent by money order is received in the Branch Office, an indication to this effect may be made in the 'remarks' column of schedule sheet against the appropriate entry. The schedule sheet relating to money order payments should be reviewed by the Branch Office by the 15th of every month and should include all payments made upto 15th of the previous month. Cases in which acknowledgements have not been received should be entered in a register. The receipt of outstanding payees' acknowledgements should be watched carefully and regularly from this register and in case an acknowledgement is not received the matter should be taken up by the Manager with the postal authorities. With a view to avoid frequent references in individual cases, a monthly statement in duplicate indicating all the cases for which payees' acknowledgements have not been received may be sent to the postal authorities and they may be requested to return one copy of the statement after indicating the position of each remittance. The replies of the postal authorities in the statement may fall into the following three categories and the action to be taken thereon is indicated against each: -
- (a) If the reply is "matter being investigated", no further action is required to be taken by the Branch Office except that a further reply may be watched from the postal authorities. If no reply is received by the time the next month's statement becomes due, this case may be entered therein with suitable remarks.
- (b) If the reply is "payment has been made; certificate of payment (or attested copy of acknowledgement with post office) enclosed", then the individual certificates may be treated as acknowledgement. If the certificate is a consolidated one then note will have to be made on the payment docket with cross reference to the consolidated certificate.
- (c) In some cases no reply may be received from the postal authorities even after reminders. Such cases may be reported to the Regional Office for further action. As the number of cases to be pursued each month in any one Branch Office will be small, these cases can be pursued through separate file till each case is disposed of. Where money order acknowledgements are not received inspite of repeated reminders to the postal authorities and insured person has not claimed benefit within a year, the Regional Director may condone the irregularity in consultation with the Deputy Director (Finance) at Regional Office.
- (v) The BM should also ensure that the signature of the insured person on the payee's acknowledgement is compared with the signature given in the claim form, so as to avoid any possibility of fraud, i. e., receipt of benefit in fictitious names.
- (vi) In case the amount sent to an insured person by money order is returned by the post office, the amount will be entered in the cash book A/c. No. 2 and the insured person will get the credit of the amount of benefit. The docket will then be cancelled and relevant columns of ledger will also be cancelled by the Manager, indicating in the remarks column the reason for such cancellation. The relevant money order coupon should be kept in its place in serial order in bundle of payees' acknowledgements to enable verification of the receipted and the unreceipted money order claims at the same time by audit.

- (vii) (a) If blank money order forms are available on payment, these may be kept in safe custody by the Cashier. The cost of blank money order forms lying with Cashier forms part of cash just like revenue stamps.
- (b) The remittance charges to be recorded for each transaction should be the total money order commission actually paid plus cost of money order forms.
- (c) For each payment of benefit to insured persons made by money order at the cost of the Corporation, the remittance charges will be debited under the head "C-Other benefits (G) Misc."
- (viii) Benefit once remitted at the cost of the Corporation, if returned undelivered cannot be remitted again at the cost of the Corporation. The amount can, however, be remitted at the cost of the beneficiary if so desired by him.
- (ix) When a benefit is remitted at the cost of insured person, only the net amount, i. e., the amount due reduced by the money order commission actually payable together with cost of money order form should be remitted.
- (x) In case any money order form is spoiled and made unusable, the Standing Committee has delegated powers to the Regional Director "to write off expenditure on the spoilage of money order forms up to 1% of the total money order forms used during the financial year for remittance of cash benefits". The Branch Office should exercise utmost care in writing the form so as to avoid any spoilage. Where, however, any such spoilage takes place inadvertently, a reference should be made to the Regional Director to write off the expenditure.

Checker's role

P.3.34. The claims clerk will submit every claim prepared by him, along with the supporting papers, the ledger, the docket and the slip to the checker who will check and tick the same in every detail as well as the documents supporting it, record his dated initials in every space provided and required and pass on the complete papers and documents to the Manager. When a claim is to be rejected, the checker will sign the regret slip prepared by the claim clerk.

P.3.35. Where no checker has been provided or is unavailable, claims will be checked by the Head Clerk or if even a Head Clerk is not provided, by another clerk. Minor mistakes may be got amended so as to avoid delay. Any correction made by the Checker in the documents should be initialled by him.

P.3.36. Any minor errors noticed in claims documents may be corrected by the checker over his initials. For major mistakes, the papers should be returned to the claim clerk for correction and resubmission.

Manager's role

P.3.37. Every claim should be checked in 100% cases before Manager records his pay order. In addition to the scrutiny of the claim by a checker, it is the responsibility of the Manager to scrutinise the claim thoroughly before recording his pay order. Any correction made by the Manager in benefit payment docket should be initialled by him.

P.3.38. Where the mistake is fundamental, e. g., claim is not payable while it was considered payable by the claims clerk, or *vice versa*, the checker will bring the matter to the notice of the Manager and get the necessary orders. Action should then be taken in accordance with the decision of the Manager.

Old and unpaid certificates

P.3.39. The certificates pending for more than a month in the bundles of current certificates with the claims clerks have to be removed from those bundles and rubber stamped as “OLD”. With a view to avoid misuse of these old and unpaid certificates, the Manager has to keep them in Insurance No. order in his personal safe custody. Payments on such certificates should be made after establishing the identity of the IPs. With regard to payments made at the pay offices on such old certificates the Cashier should take special care to establish the identity of the IPs before making the payments.

Passing claims during Manager’s absence

P.3.40. Whenever a Manager leaves office or is away from it for a whole working day due to casual leave or on court duty or other office work, a Head Clerk, if posted in the Branch Office, is authorised to exercise the powers of Manager in regard to passing of the following claims :-

- (a) Sickness benefit
- (b) Extended sickness benefit (after first payment)
- (c) Temporary disablement benefit (after admittance as employment injury by Manager or Regional Office)
- (d) Maternity benefit (after first payment)
- (e) Permanent disablement benefit and dependants' benefit (after first payment)

There will be no need for the Manager to accord *post-facto* sanction to these claims passed by the Head Clerk.

P.3.41. A UDC wherever posted in the Branch Office may also pass provisionally claims at (a) to (e) of the foregoing para during the temporary absence of Branch Manager on casual leave or court work or other office work, subject to *post-facto* checking by Manager on return. It may, however, be ensured that a UDC entrusted with these powers should have put in at least 4 years’ continuous service in the Corporation including his service as LDC. In the absence of the above officials, the UDC Cashier may pass provisionally the benefit claims. The UDC Cashier in these cases has also to sign the relevant columns of the ledger in token of having admitted the claim. The Manager, while according his *post-facto* sanction, should also sign in the same column in which UDC Cashier has already signed. The counter-signing authority will be responsible for the wrong payments if the mistake is pointed out after his counter-signatures. The UDC Cashier-checker and the claims clerk will also of course be responsible. If, however, the Manager while countersigning detects a wrong payment and records this fact on the payment docket, the UDC-Cashier (who passed the claim) alongwith the checker and the claims clerk will be responsible for the wrong payment, if any.

P.3.42. The Head Clerk/Upper Division Clerk/UDC Cashier should, however, leave first payment of permanent disablement benefit and dependants' benefit to be paid on the authority of the Manager. Also cases where Manager has to exercise power under, say, Regulation 64 or take a decision, say, under Regulation 53, should await Manager’s return to office. Cases where total amount of payment to an insured person/dependant exceeds Rs. 2000/- should also await Manager’s return.

Payment on admitted claims

P.3.43. The Cashier will receive the ledger with the benefit payment docket after the claim has been passed by the Manager. He should call the insured person, make sure of the identity with reference to his photograph on the identity card and also by looking at his age, asking for his name, father's name, the reason which necessitated abstention from work on medical grounds etc. and compare them with the particulars on identity card and the claim/certificates etc. In case of doubt, he should immediately refer him to the Manager, and should take further action in accordance with his instructions.

P.3.44. In all cases where the amount of benefit on any day to a particular insured person exceeds Rs. 1500/- the payment should be made in the presence of the Manager so that he may fully satisfy himself about the correct identity of the payee. The Manager should in that case write on the payment docket "Paid in my presence" under his dated signatures. In case of payment at Pay Office, the Cashier may make the payment exceeding an amount of Rs. 1500/- in the presence of factory labour officer or any managerial officer who may record the words on the payment docket – 'Paid in my presence' over his signature and designation. However, the certificate "Paid in my presence" is not required to be recorded in cases where the payment is made by cheque or by demand draft. The foregoing instructions also apply to payments involving more than one docket each of which is singly less than Rs. 1500/- but the aggregate of which exceeds Rs. 1500/-.

P.3.45. The Cashier should obtain a properly signed receipt from the insured person before making payment. The insured person will sign the benefit payment docket or affix his left thumb impression thereon at the space provided for the purpose. A female claimant will affix her right thumb impression. The thumb impression should also be attested by a person known to the Branch Office. Another insured person can attest the thumb impression provided his signatures tally with that on his own identity card and he can be identified from his photograph on it. The insurance number of the insured person attesting the thumb impression should be indicated below his signature. In other cases, the designation etc. of the person attesting, e. g., employer's representative, a union official, may be clearly indicated (with rubber stamp, if possible). As far as possible, attestation should not be done by any member of the staff of the Branch Office.

P.3.46. In case payment is to be received by the agent, he should submit a receipt duly signed by the insured person for the amount of benefit. The Manager should also call upon the agent to give certificate of the payment received by him and such a certificate should form part of the acquittance for the payment.

P.3.47. In cases where the Cashier is fully satisfied about the correct identity of the insured person from the photograph on the identity card, attestation of the thumb impression by another person known to the Branch Office need not be insisted upon. However, the cashier/teller in such cases would record a certificate over his dated signatures on the docket to the effect that identity has been established from the photograph/identification marks on the identity card beyond any doubt.

P.3.48. The Cashier should also check that the signature or thumb impression on the payment docket tallies with the one indicated on the identity card and on the claim. In case there is some variation, the Manager should, after satisfying himself about the identity of the person, attest the same before the payment is made. Thumb impression may not be capable of minute comparison but no noticeable difference should be overlooked.

P.3.49. The Cashier will, however, be personally responsible for any wrong payment made by him. If the cashier has any doubt about the correct identity of the payee, he should obtain the written orders of the Manager before making payment.

P.3.50. For obtaining the thumb impression of the insured person on the docket, pad ink should be used and not ordinary writing ink.

P.3.51. Where left thumb of the insured person or right thumb of an insured woman is missing, the impression of the other thumb may be taken and the fact should be duly recorded on the payment docket. When both thumbs are missing, if finger impression can be taken in any particular case, payment may be made on furnishing satisfactory identification by a person known to the paying authority recording the fact of identification on the payment docket. If even finger impressions are not possible, the private scar or mark of the person duly attested by a proper identifier may also serve the purpose.

P.3.52. After obtaining the LTI/RTI/signature of the claimant and satisfying himself about his/her identity, the cashier will give the claim a quick look to see if the amount of pay order is in fact the arithmetical product of the rate and the number of days shown in the docket.

P.3.53. In case the amount of benefit exceeds Rs. 5000/-, a stamped receipt should be taken, i. e., bearing a revenue stamp of one rupee from the insured person. In such cases where there are more than one payment dockets in respect of the same insured person, besides obtaining acquittance of the insured person on each docket, revenue stamp should also be affixed on each docket on which the amount exceeds Rs. 5000/-. Of course, such a payment will be made by a crossed cheque only.

P.3.54. If the amount of benefit exceeds Rs.3000/-, it is to be compulsorily paid by a crossed cheque account payee or by demand draft at payee's option Amount of Account payee cheques issued by the Branch Manager to IPs towards payment of cash benefits are no longer counted against daily and monthly withdrawal limits of the Branch Manager. Please see in this connection para 14.2.3(3) of Chapter XIV.

P.3.54A An Account payee cheque/demand draft can only be credited to the payee's account. Often, the recipient of such a cheque / draft may first have to open a savings account with the bank/post office but without proof of his identity to its satisfaction, the bank/post office may decline to open his account. If such a claimant approaches the Branch Office for guidance/help, the Manager may issue him an introductory letter certifying his name, father's name, insurance number, employer's name and permanent address of the I.P. on the basis of his records in the Branch Office. A specimen is at Annexure IV B. A copy of circular letter No. 113-6/2002-SB dated 18.07.2002 issued by Shri R. Handa, Deputy Director General (FS), Department of Posts (SB Division), New Delhi 110001, to Heads of Circles, copy at Annexure IV C, may be attached to the Manager's letter to the post office. In this letter, all post offices have been directed to open the savings accounts of the IP's on production of introductory letter from the Branch Office along with the photo identity card of the I.P. issued by the Branch Office. A photocopy of the circular letter issued by the Department of posts may also be provided to the post office.

Record of payments made – schedule sheet

P.3.55. The cashier should put the rubber stamp "PAID" and state the date of payment on the benefit payment docket and slip. "PAID" stamp will also be affixed on each claim form. Affixation of "PAID" stamp is not necessary where the word 'paid' is already printed on the docket. The Cashier will also simultaneously make entries in appropriate columns of the ledger sheet of each insured person and the schedule sheet (form MISLO-01) and initial the same with date. He will also state the following words in each payment docket "Entries made in columns 19-21". A rubber stamp may be made for this purpose. These words may also be got printed in the payment docket, thus eliminating the need for rubber stamp. He will then pay the amount in cash after deducting the value of revenue stamp(s) to the insured person or his agent, as the case may be, and hand over the slip(s) to him. The Cashier will retain the dockets and release the ledgers and return them to the claims clerk.

P.3.56. The serial number of payment as noted in the payment schedule should be indicated by Cashier on the benefit payment docket at the space meant for schedule sheet no. on the top. The docket will be tagged in serial order, as and when payments are made by the Cashier.

P.3.57. Cash benefits under the Act are paid to the insured persons (i) in cash (ii) by money order and (iii) by cheques etc. and the Branch Office should prepare a combined schedule for payments by money order and payments by cash. However, a separate schedule should be maintained for payments made through cheques etc. The mode of payment should be indicated on the schedule in the appropriate column. The Cashier should prepare the schedule in triplicate, one copy to be displayed on the notice board for three days.

P.3.58. After payment hours, the Cashier will complete totals of schedule sheet and tally the cash in hand with the balance as indicated by the payments recorded.

P.3.59A. Each individual payment recorded in the schedule, i. e., the original copy, is to be attested with date by the Manager. The totals for the day worked out on this schedule in respect of each benefit are only recorded in cash book A/c. No. 2. Each entry in the cash book should be attested with date by the Manager and it should be closed and balanced daily. The Manager will submit daily the original schedule of benefits paid alongwith a summary of receipts and payments in form A-19 in respect of Account No. 2 of his Branch Office to Deputy Director (Finance) as far as possible on the same working day or latest by the next working day. Similarly, the Manager would also submit a monthly summary of receipts and payments in A/c. No. 2 in form A-19 on the last working day of the month itself. Form A-19 is now re-numbered as MISLO-02.

P.3.59B. Where there is no cash transaction on a particular day, Branch Manager should send an intimation to the Regional Director giving reasons therefor so that the Regional Director may take such action as may be deemed necessary in the circumstances of the case. The Regional Deputy Director (Finance) should also be informed for completion of his record.

P.3.60. While preparing the schedule the following points should be kept in view :-

- (a) Payments of the following occasional nature which are made from Account No. 2 should be recorded in the blank column of the schedule. In case payments relating to more than one item are made on any particular day, the remarks column may be utilised.
 - (i) Conveyance charges and/or loss of wages paid to an insured persons.
 - (ii) Miscellaneous expenses including charges payable to police authorities for obtaining police reports and other statements for deciding cases of employment injury.
 - (iii) Payments to members of medical board.
 - (iv) Fees paid for post mortem examination.
 - (v) Pension to retired employees.
- (b) Money order remittance charges borne by the Corporation have to be shown separately in the schedule sheet. In regard to payments made by money order at the cost of the beneficiary, the total amount of the benefit including remittance charges should be shown under the relevant benefit column to which it relates.
- (c) Recovery of benefits overpaid etc., through adjustment from benefit paid, are exhibited in the schedule sheet in the following manner:
 - (i) Where recovery of overpayment is made (by adjustment) from the same benefit during the same year, the net amount of benefit is only shown in the schedule sheet, with suitable remarks in the remarks column to explain the transaction.

- (ii) Where recovery is made from a different benefit during the same year, gross amount of benefit is shown under the relevant columns and the amount of benefit recovered through adjustment is shown as a minus entry under the relevant column of benefit.
- (iii) When recovery of amount pertaining to a previous year is made, the amount recovered will be shown distinctly as revenue under the head “VII-MISC-MISC”.

P.3.61. The number and date of the cheques by which payments are made should be indicated at the end of Form MISLO-01 prepared for the purpose. The Branch Manager should also give a pay order at the end of the schedule (form MISLO-01) for the aggregate amount of money order commission incurred (including the cost of money order forms used).

P.3.62. In addition to the existing certificate printed on the schedule the Branch Manager should also record the following certificate at the end of the Schedule, immediately below the existing certificate in the Schedule :-

“Certified that for all the payments included in this schedule the dockets are held by the Branch Office”.

P.3.63. Information regarding fresh claims is required by Headquarters for statistical purposes and must be furnished with the utmost accuracy. For this, the checker while checking each claim should indicate ‘F’ on the right hand top corner of the docket in respect of fresh claims, viz., those which are being paid for the first time, i.e., those bearing a first certificate in case of sickness benefit and temporary disablement benefit, etc. The Manager while checking and passing the claim for payment will also check this entry and tick it. The Cashier at the time of payment will enter the letter ‘F’ in the schedule of benefits paid in the remarks column. These ‘F’s under different benefits will be totalled up and entered each day in the statistical data for compilation of the monthly progress report of the Branch Office.

P.3.64. Fact of exhaustion of sickness benefit has also to be indicated by means of letters EX or EXI as the case may be, in red ink immediately below the progressive total noted in the ledger. EX is the abbreviation to denote that it has been exhausted in one spell and EXI will denote that it has been exhausted in separate spells. From the ledger, the Cashier will make these entries in the remarks column of the schedule of benefits paid (MISLO-01 – old form no. ESIC-19).

Monthly totals of each benefit payment

P.3.65. Triplicate copies of schedules are to be retained at Branch Office. The schedules should be arranged chronologically in a separate file for each month. At the beginning of the file, a flyleaf should be kept for recording the number of payments and amount paid at the Branch Office on each day in the following form :-

Date	Sickness Benefit				Maternity Benefit			
	No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made
1	2	3	4	5	6	7	8	9

Temporary Disablement Benefit				Permanent Disablement Benefit			
No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made
10	11	12	13	14	15	16	17

Dependants' Benefit				Extended Sickness Benefit			
No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount (Rs.)	No. of fresh claims on which payments made
18	19	20	21	22	23	24	25

Funeral Expenses		Total		
No. of payments	Amount paid (Rs.)	No. of payments	No. of Benefit days	Amount (Rs.)
26	27	28	29	30

At the end of the month, the totals should be struck for each benefit and progressive totals for all benefit payments should be recorded as follows :-

	No. of Payments	Amount paid (Rs.)
Total for the month		
Total from 1 st April to end of previous month		
Total from 1 st April to end of this month		

P.3.65A Apart from payments of B-Cash Benefits, other payments are also made from A/c No. 2 and recorded in the cash book, e.g. money order commissioner paid, conveyance charges/ loss of wages compensation paid to IPs, etc.. Since these payments are few, figures of expenditure incurred on these items shall also form part of the monthly summary and can be picked up from daily returns in form A-19 for the month and included in the monthly return in form A-19 which will accompany the return of cash benefits paid.

P.3.66. This fly-leaf and the schedule of benefits paid for each month should be stitched together in the form of a book and the stitched file kept under lock-and-key in a steel cup-board for a period of one year. There is no objection to keep these files in open cup-boards after the expiry of one year. The Manager should take great care to ensure that no schedules are lost as they form important documents relating to the cash payments. The entries posted in the fly-leaf will enable the Branch Office to see at a glance the number of payments and amount paid from the beginning of the financial year to date.

Safe custody of payment dockets

P.3.67. The Manager should ensure that all the payment dockets are kept with utmost care. All precautions for the safe custody of the documents of such importance should be scrupulously observed. In case of any loss/misplacement of dockets, the matter should immediately be investigated and reference made to the Regional Director alongwith explanation of the official concerned and comments of the Manager.

P.3.68. The following procedure shall be followed to ensure security of payment dockets and fixation of responsibility in the event of loss:-

- (1) The Branch Manager must ensure that the payment dockets are kept in his safe custody in the almirah under lock and key. He should exercise due vigilance and proper supervision in regard to handling of payment dockets.
- (2) Articles of stationery etc. should not be kept in the almirah in which dockets are kept.
- (3) If the number of almirahs for keeping dockets is not adequate, the Regional Director should arrange to get adequate number of steel almirahs/steel boxes supplied to Branch Manager for the purpose. If the requirements are in excess of yardstick, General Branch of headquarters may be approached for sanction.
- (4) So far as audit is concerned, acknowledgement may be obtained for the number of bundles handed over to and taken back from the audit party.
- (5) Where there is change of Branch Manager, due receipt may be given for the number of bundles of dockets for the period not audited.
- (6) Whenever a Cashier, UDC or any other member of the staff wants to refer to any docket-cum-certificate, he should do so in the presence of the Manager and the docket or the bundle taken out must be replaced in its proper place forthwith after needful is done. The Manager may, however, exercise his own judgement in fulfilling this requirement in the conditions prevailing. At the same time, however, he will assume full responsibility and should be answerable for any loss or misplacement of dockets.
- (7) Normally no one other than the Manager, the Cashier or the Head Clerk should be permitted to handle the dockets.
- (8) The question of safe custody of payment dockets-cum-certificates by the Manager should also form important item of inspection of the Branch Office by an inspecting authority.

Payment by cheque

P.3.69. Where payment is to be made by cheque, the cashier will prepare an account payee cheque for the amount of benefit in favour of the insured person on the cheque book of Account No. 2 of the Branch Office, make necessary entry in the cheque drawn register and place it before Manager for his signature. The cheque will be signed by the Manager and handed over to the cashier. The insured person's

signature will be taken on the counterfoil of the cheque in token of its receipt. The Manager will also sign in column No. 7 of the Register. In these cases, the words “by cheque” will be added in the benefit payment docket after “Received payment” before obtaining the signature of the insured person. The cheque will then be handed over to him. This will serve as the receipt of the insured person for the amount of benefit paid to him by cheque. It will bear a stamped receipt if amount exceeds Rs. 5000/-. Apart from the special instructions in this para further action on claims paid by cheque will be the same as explained earlier.

Claims passed but not paid

P.3.70. Besides the claims paid in cash, or by cheque or by money order, there may be claims which, though passed on a particular day, may not be paid on the same day for certain reasons, e. g., the insured person going away without waiting to receive payment. Such claims will be entered in a separate register on form ESIC-21 “Register of Claims Passed but Not Paid”.

P.3.71. The benefit payment dockets relating to such cases will be retained by the Cashier who will release the ledgers. When insured person comes to take payment, benefit will be paid to him and further action taken including entry in ESIC-19 for the day and in the relevant ledger sheet. Date of payment will invariably be entered in the column No. 7 of ESIC-21. In case of a passed claim when payment is delayed beyond 15 days, the Cashier should make the payment to the insured person only after bringing it to the notice of the Manager.

P.3.72. The Manager should periodically review this register. If a payment has not been made within one month of the date of admittance of claim, the docket will be cancelled by him over his initials, after making an entry to this effect in ESIC-21 with which the cancelled docket may also be tagged for easy reference when required. The entries of benefit made in the ledger sheet should also be cancelled and remarks recorded in the columns meant for entries by Cashier “Payment not made as IP failed to turn up for payment”, over Manager’s signature. The certificates and claims will be kept in the safe custody of Manager in the bundle of ‘old’ certificates.

Payee’s acquittance on docket

P.3.73. Every disbursing official of the Corporation is personally responsible to see that for every payment made by him, he obtains a proper payee’s receipt so as to vouch for cash paid and also that a second claim, if made by the payee on the same account, etc., is not paid. Quite apart from the responsibility of the Cashier to obtain payee’s receipt, it is the personal responsibility of the Manager also who is the disbursing officer of the Corporation to see and verify at the time of signing cash accounts at the end of each day that the Cashier has obtained a proper voucher with payee’s receipt for every payment made by him and included in the day’s cash account

P.3.74. A payment made without obtaining payee’s acquittance is not considered valid payment and, therefore, it cannot be entered in the schedule of benefit payments nor entered in the cash book. If the cashier fails to obtain the acquittance which is his duty to do, he is personally responsible for the resulting shortage in the cash balance.

P.3.75. As already stated, the Manager should ensure that every payment docket included in the schedule of benefit payments for the day bears the acknowledgement of the payee. If he detects a docket without payee’s acknowledgement, he should give the Cashier an opportunity to obtain the acquittance of the payee by the close of business on the same day or until the morning of the next working day. The accounts for the day can be finalised and cash book for the day written before the start of transactions on the next working day. If the Cashier is unable to obtain valid acquittance from the payee before the start of the next day’s transactions, he would be held personally responsible for the shortage in cash balance and action taken in accordance with para 74 of the Manual of Audit & Accounts Vol. I, which is reproduced below for ready reference.

“Discrepancies in Cash Balance

74. The discrepancies noted in cash balances, on physical verification, should be reported immediately by the cashier and/or Manager without delay and should be dealt with as follows :-

Deficit in Cash balance- This must be made good before the employee concerned leaves his place of duty and the fact must also be recorded in the cash book. The Head of the Office or other officer in-charge of cash, should make necessary note of this fact in the cash book, under his dated signature. He should also institute necessary inquiries in the matter and submit a report to the Headquarters Office through proper channel where necessary, as soon as possible after the incident giving his suggestions and recommendations.

Excess in Cash Balance- The amount should be entered separately in the Cash Book and the necessary note made therein by the Head of the Office or the officer incharge of cash, under his dated signature. An investigation may then be made and pending finalisation of the investigation proceedings, the amount should be taken under ‘Deposits-(c) Miscellaneous’ in the accounts.

Director General’s decision

Individual cases of deficit/excess in the cash balance where the amount involved does not exceed Rs. 5/- and where the shortages have been made good by the persons concerned, need not be reported by the Branch Manager to the Regional Director. Such cases may be finalised by the Branch Manager where person at fault should be cautioned in writing. A record of all such cases indicating clearly the action taken, if any, should, however, be maintained and the visiting officers of Regional Offices may review these cases at the time of their inspections.

Cases where the amount of excess/deficit exceeds Rs. 5/- or where the deficit of less than Rs. 5/- each has occurred more than twice in a month in an office in a particular case, there is reason to believe that there is deliberate loss or an instance of carelessness on the part of an employee. Such cases should be reported every month to the Regional Director with complete details for taking further necessary action against the persons concerned in accordance with the procedure prescribed in the Employees’ State Insurance Corporation (Staff and Conditions of Service) Regulations, 1959.”

Deficit in cash balance

P.3.76.1. When a docket without acquittance has been entered in the schedule sheet and payment booked in cash book, responsibility lies on the disbursing official as well as on the Manager. In case such a payment is not proved, the amount is likely to be realised from the employee(s) of the Corporation jointly or severally.

P.3.76.2. The Branch Manager is also personally responsible for the correctness of entries made by the Cashier in the schedule of benefits paid. While there is no harm if the Branch Manager is assisted in this work by the Head Clerk, the personal responsibility of Manager will not thereby be diminished.

P.3.77. While checking the docket and the schedule, the Manager should also get each payment docket for which there is an entry in the schedule stamped as “cancelled” in his presence. The stamp “cancelled” should be affixed on the pay order recorded on the docket especially over the signature of the Manager. This cancellation by the Manager will be in addition to the stamp affixed as “paid” by the Cashier.

Preparation of duplicate docket

P.3.78. Where it is represented by an insured person that he did not receive payment of benefit and the ledger sheet on verification is also found to be without entries in columns 19-21, a duplicate docket may have to be prepared if the original one is not traceable. But, before this is undertaken, Manager will have to satisfy himself fully that payment of benefit was really not made. A written representation of the insured person should be obtained for this purpose and register of claims passed but not paid should be helpful in tracing out the claim provided it had been passed by Manager. The certificates of this IP would be lying in personal custody of the claims clerk or of the Manager if these have become 'old'. If no entry was made in the register of claims passed but not paid, it will be necessary to verify the entries in the schedule from the date on which the claim was prepared and dates occurring thereafter, before payment can be authorised on duplicate docket. Possibility of fraud being present, utmost care should be taken in handling such cases.

Benefit due at the time of death

P.3.79.1. Under Section 71, the benefit which was due to the deceased insured person during his life time is to be paid to a person whom the insured person had nominated; a nomination under this section, if found valid, serves to fulfil the deceased insured person's wish as if he himself would receive the amount. In this respect, a nomination under Section 71 is different from dependants' benefit which the Act specially ordains to be paid to the defined dependants or funeral expenses which is paid to compensate for the expenditure incurred on the insured person's death to a person who has actually incurred it.

P.3.79.2. Central Rule 56(2) introduces another type of nominee, viz., one named by the insured woman to receive payments of maternity benefit on her child's behalf if she dies during her delivery or during the period immediately following the date of her delivery provided her new-born infant remains alive.

P.3.79.3. In both cases the insured person/insured woman gives the name of the nominee at the time of filling the declaration form and it is this declaration which helps the Corporation to decide on the nomination question.

P.3.79.4. The following procedure will be followed in the matter of payment of benefit due to an IP/IW at the time of his/her death:-

- (a) As soon as Branch Manager comes to know of the death of an IP/IW, he should ascertain from records at the Branch Office if any cash benefit has remained prima-facie due, yet unpaid to him/her..
- (b) If any benefit is found payable, the name of his/her nominee as recorded in his/her declaration form will be called for either from the Regional Office if deceased IP's/IW's declaration form may be lying there, or at the Branch Office itself.
- (c) A claimant may soon approach the Branch Manager for payment of benefit. If the claimant is found to be the nominee, he/she will be called upon to complete a regular claim for the period for which the benefit was payable to the deceased insured person. The Branch Office will also first satisfy itself about the identity of the nominee from a certificate from a magistrate or gazetted officer or the president of a village panchayat, etc. The amount of benefit will then be paid to him/her. The action at the Branch Office regarding diarising the claim, making entries in the ledger, preparation of benefit payment docket and slip will be just as in the case of other claims.
- (d) If the Branch Office finds that the applicant is not the nominee, he/she will be informed accordingly and the Branch Office will advise the nominee to come and take payment. In case the nominee is residing outside, the Branch Office will send a claim form duly completed advising the nominee to return it duly signed and attested by a magistrate or gazetted officer or president of a village panchayat etc., alongwith a request for making payment by money

order. When the claim complete in all respects is received, the claims clerk will take necessary action for payment.

P.3.80. If it is found that the deceased insured person had not made any nomination or the nomination so made has become invalid, payment will be made to the deceased's heir or heirs as follows:-

- (a) If the amount of benefit is upto Rs. 1,000/- payment will be made to the legal heir(s) on submission of a declaration in Form ESIC-63A (Annexure V).
- (b) If the amount of benefit exceeds Rs. 1000/- but does not exceed Rs. 10,000/-, payment will be made to the legal heir(s) on submission of an indemnity bond (see Annexure VI) with two sureties (see Annexure VII) for a like amount. Both the bonds will be on stamped paper of appropriate value in consultation with local counsel.
- (c) If the amount is more than Rs. 10,000/-, payment will be made to the legal heir(s) on production of a succession certificate from a competent authority, or on production of a certificate of Administrator General under the Administrator General Act 1963.

P.3.81. The Branch Manager should keep the following in view while dealing with cases of nomination etc. :-

- (a) A nomination made by the insured person becomes invalid if the nominee predeceases the insured person.
- (b) A nominee may survive the insured person but may die before the payment of benefit due to the deceased insured person could be made to him. In that event, benefit due to the insured person at the time of his death will be payable to his legal heirs only and not to heirs of the nominee.

Where there is a contest between the rival claimants, the Branch Manager should either resort to an inter pleader or insist upon a succession certificate, as payment to the holder of the succession certificate will operate as a complete legal discharge.

Dependants' benefit due to a deceased dependant

P.3.82. No nomination is necessary for making payment of dependants' benefit dues in case of dependant on his/her death. Payment of dependants' benefit in respect of a deceased dependant due at the time of his/her death may be made in the same manner as provided in the preceding para applicable in cases where no nomination is made or the nomination made has become invalid. Before authorising payment in the above manner, Regional Director should enquire into the rights and title of the claimants and their relationship to the deceased etc. to satisfy himself about the correctness of title to the payment.

Payment to a lunatic

P.3.83. In cases where a magistrate has certified an insured person to be a lunatic, the payment of benefit due to such an insured person may be made in accordance with Section 95 of the Indian Lunacy Act, which reads as under :-

Section 95 of the Indian Lunacy Act:

- “(1) When any sum is payable in respect of pay, pension, gratuity or other similar allowance to any person (by the Central Government or any provincial government) and the person to whom the sum is payable is certified by a magistrate to be a lunatic, the Government Officer under whose authority such sum would be payable if the payee were not a lunatic may pay so much of the said sum as he thinks fit to the person having charge of the lunatic and may pay

the surplus, if any, or such part thereof as he thinks fit, for the maintenance of such members of the lunatic's family as are dependant on him for maintenance.

(2) The Government.....(concerned) shall be discharged of all liabilities in respect of any amounts paid in accordance with this section.”

P.3.84. The Corporation may be treated as if it were part of the Central Government for the purpose of Section 95 of the Lunacy Act. Payment can be made accordingly.

P.3.85. Where an insured person/claimant is not certified to be lunatic by a magistrate, the payment should be made to the insured person and to no one else and the receipt should be obtained from him. However, to mitigate hardship, the payment may be made to the insured person in the presence of his father, mother, wife, husband or a major son, who may witness the payment and take charge of the amount with the consent of the insured person.

Payment hours

P.3.86. The Insured Persons are facing great difficulties in receiving their benefit payments due to late opening & early closing of branch offices. Hqrs decided that the cash payment to the insured persons should start as soon after opening of the Branch Office as possible but in any case not later than 45 minutes after the commencement of the normal office time and should continue until 1.5 hours before closing time. Working days and payment hours should be conspicuously displayed in local language at the Branch Office.

Certain other matters connected with claims payments

P.3.87. Certain other matters connected with claims payments, e.g., incapacity references, abstention verification, time-barred claims, excess or wrong payments, and high incidence of claims etc. are discussed in Chapter XI dealing with miscellaneous matters connected with claims and payments. Further, any specific problems relating to a particular benefit will be found in detail in the relevant chapter on that benefit.

**BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION**

No.....

Re. Shri.....

Ins. No.....

To

I have to request you to kindly fill in the following particulars of periods of absence of the above mentioned employee since.....or the date of entry into your employment, whichever is later. The information is required to check up and dispose of the claims submitted by the insured person. I shall be grateful for your co-operation.

Sl. No.	Period of absence		Reasons for absence	Remarks, if any
	From	To		

Yours faithfully,

MANAGER

Returned in original after filling in the columns as desired.

.....
Rubber Stamp and Signature of Employer

**BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION**

Ref. No.....

To

Dear Doctor,

Ref: Shri.....Insurance No.....

I have to request you kindly to fill in the following particulars regarding the certificates, if any, issued by you to the above mentioned insured person since.....or the date of his registration with you whichever is later. This information may be readily available from the medical record envelope maintained by you in respect of the insured person. I am sorry to give you this trouble but the information is required for disposal of the claim of the insured person and I trust you will give us your co-operation.

Sl. No.	Nature of certificate	Date of issue	Period covered	
			From	To

Yours faithfully,

MANAGER

Returned in original after filling in the columns as desired.

.....
Rubber stamp and signature of
Insurance Medical Officer/Practitioner

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

Ref. No.....

Date.....

To

The Regional Director,
ESI Corporation,

Sub.: Non availability of ledger sheet of
Shri_____

Insurance No_____

Sir,

I have to state that in spite of best efforts it has not been possible for this office to trace the ledger sheet of the above mentioned insured person. Letters to the employer and to the doctor have been issued with a view to ascertain if any benefit has been drawn by the insured person previously. I have to request that a fresh ledger sheet in respect of the IP may now be got printed and supplied urgently so that the claim submitted by the insured person may be disposed of.

Yours faithfully,

MANAGER

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

Declaration from an insured person whose ledger sheet is not traceable

I Ins. No..... employed in hereby declare that I have not submitted any claim for sickness and/or maternity benefit, nor drawn any such benefit from any of the offices of the Corporation since I had submitted claims for sickness and/or maternity benefit and drawn benefit only as indicated below :-

Sl. No.	Period for which certificate submitted		Nature of certificate	Period for which benefit drawn		Nature of benefit	Amount of benefit received	Remarks, if any (the No. and date of the payment slip, if available with the IP)
	From	To		From	To			

2. I do hereby undertake to indemnify the Corporation against any loss that may be suffered by the Corporation as a result of this declaration.

Witness:

*Signature
or*

Date:

Thumb Impression

This declaration was given in my presence

MANAGER

S. No.	Average daily wage		Standard Benefit Rate	w.e.f. 01.12.07		S. No.	Average daily wage		Standard Benefit Rate	w.e.f. 01.12.07	
	Lower	Upper		SB Rate	TDB Rate		Lower	Upper		SB Rate	TDB Rate
1	2	3	4	5	6	7	8	9	10	11	12
1		24.34	14	16.80	21	51	408.70	417.39	240	288	360
2	24.35	27.82	16	19.20	24	52	417.40	426.08	245	294	367.50
3	27.83	31.30	18	21.60	27	53	426.09	434.78	250	300	375
4	31.31	34.78	20	24.00	30	54	434.79	443.47	255	306	382.50
5	34.79	41.73	24	28.80	36	55	443.48	452.17	260	312	390
6	41.74	48.69	28	33.60	42	56	452.18	460.86	265	318	397.50
7	48.70	52.17	30	36.00	45	57	460.87	469.56	270	324	405
8	52.18	55.65	32	38.40	48	58	469.57	478.26	275	330	412.50
9	55.66	62.60	36	43.20	54	59	478.27	486.95	280	336	420
10	62.61	66.08	38	45.60	57	60	486.96	495.65	285	342	427.50
11	66.09	69.56	40	48.00	60	61	495.66	504.34	290	348	435
12	69.57	76.52	44	52.80	66	62	504.35	513.04	295	354	442.50
13	76.53	83.47	48	57.60	72	63	513.05	521.73	300	360	450
14	83.48	92.17	53	63.60	79.50	64	521.74	530.43	305	366	457.50
15	92.18	100.86	58	69.60	87	65	530.44	539.13	310	372	465
16	100.87	109.56	63	75.60	94.50	66	539.14	547.82	315	378	472.50
17	109.57	118.26	68	81.60	102	67	547.83	556.52	320	384	480
18	118.27	126.95	73	87.60	109.50	68	556.53	565.21	325	390	487.50
19	126.96	135.65	78	93.60	117	69	565.22	573.91	330	396	495
20	135.66	144.34	83	99.60	124.50	70	573.92	582.60	335	402	502.50
21	144.35	153.04	88	105.60	132.00	71	582.61	591.30	340	408	510
22	153.05	161.73	93	111.60	139.50	72	591.31	600.00	345	414	517.50
23	161.74	170.43	98	117.60	147	73	600.01	608.69	350	420	525
24	170.44	179.13	103	123.60	154.50	74	608.70	617.39	355	426	532.50
25	179.14	187.82	108	129.60	162	75	617.40	626.08	360	432	540
26	187.83	196.52	113	135.60	169.50	76	626.09	634.78	365	438	547.50
27	196.53	205.21	118	141.60	177	77	634.79	643.47	370	444	555
28	205.22	213.91	125	150	187.50	78	643.48	652.17	375	450	562.50
29	213.91	222.60	130	156	195	79	652.18	660.86	380	456	570
30	222.60	231.30	135	162	202.50	80	660.87	669.56	385	462	577.50
31	231.30	240.00	140	168	210	81	669.57	678.26	390	468	585
32	240.00	248.70	145	174	217.50	82	678.27	686.95	395	474	592.50
33	248.70	257.40	150	180	225	83	686.96	695.65	400	480	600
34	257.40	266.10	155	186	232.50	84	695.66	704.34	405	486	607.50
35	266.10	274.80	160	192	240	85	704.35	713.04	410	492	615
36	274.80	283.50	165	198	247.50	86	713.05	721.73	415	498	622.50
37	283.50	292.20	170	204	255	87	721.74	730.43	420	504	630
38	292.20	300.90	175	210	262.50	88	730.44	739.13	425	510	637.50
39	300.90	309.60	180	216	270	89	739.14	747.82	430	516	645
40	309.60	318.30	185	222	277.50	90	747.83	756.52	435	522	652.50
41	318.30	327.00	190	228	285	91	756.53	765.21	440	528	660
42	327.00	335.70	195	234	292.50	92	765.22	773.91	445	534	667.50
43	335.70	344.40	200	240	300	93	773.92	782.60	450	540	675
44	344.40	353.10	205	246	307.50	94	782.61	791.30	455	546	682.50
45	353.10	361.80	210	252	315	95	791.31	800.00	460	552	690
46	361.80	370.50	215	258	322.50	96	800.01	808.69	465	558	697.50
47	370.50	379.20	220	264	330	97	808.70	817.39	470	564	705
48	379.20	387.90	225	270	337.50	98	817.40	826.08	475	570	712.50
49	387.90	396.60	230	276	345	99	826.09	and above	480	576	720
50	400.01	408.69	235	282	352.50						

Note:

1. Daily rate of maternity benefit will be twice the standard benefit rate as given in columns (4) and (10) of this table.
2. Daily rate of extended sickness benefit will be 40% more than the standard benefit rate.

**BRANCH OFFICE (_____),
EMPLOYEES' STATE INSURANCE CORPORATION**

To

The Post Master,
_____,
_____.

Dear Sir,

I have the pleasure of introducing the person named below who is a bona fide insured person/
insured woman under the Employees' State Insurance Act, 1948, as amended from time to time:-

Name : Shri/Smt./Kumari. _____
Father's/Husband's Name _____
Residential address _____
Insurance Number _____
His photograph attached on top _____
Employer's name _____

He/She has been issued a photo identity card by this office and he/she will produce it before you.

It is requested that his/her savings account may kindly be opened on the basis of this letter which
has been issued in accordance with instructions contained in Department of Posts circular letter no. 113-
6/2002-SB dated 18/07/02 issued to all Heads of Circles of your department.(photocopy enclosed)

Thanking you,

Yours faithfully,

(_____)
MANAGER

Encl: -1

Government of India
Ministry of Communications & Information Technology
Department of Posts
(SB Division)

N0. 113-6/2002-SB

Dak Bhawan, New Delhi-110001

Dated: 18.07.2002

To

All Heads of Circles,
Additional D.G., APS, R.K. Puram, New Delhi

Sub : Opening of Saving Bank Account in Post Offices by insured person of ESI Corporation.

Sir,

At present vide D.G. Post's letter No. 35-38/90-SB dated 22.11.1990 introduction of the depositor is necessary at the time of opening of individual saving accounts in the Post Office. The Employees State Insurance Corporation, New Delhi has approached to the Director General (Posts) regarding difficulties being faced by the insured persons registered under ESI Scheme in opening saving bank account in Post Office. ESI Corporation makes payment of cash benefit exceeding Rs.2000/- by cheque for which the insured persons have to open an account in bank or in Post Office.

2. As the insured persons may not know anybody to introduce them neither do they have ration card/voter card, they find difficult to open a saving bank account. In order to facilitate the insured persons, the matter has been examined in the Dte. and it has been decided that saving accounts may be opened for insured persons of ESI Corporation on the basis of the following documents:

- (a) Introductory letter from Manager of local office, ESI Corporation with whom the worker is registered;
- (b) Photo-identity-card issued by the local office.

3. It is requested that the instructions may be brought to the notice of all operative staff in your circle for compliance.

Yours faithfully,

Sd/-
(R. Handa)
Dy. Director General (FS)

Copy to Shri V. L. Nagar, Addl.
Commissioner, ESI Corporation, New Delhi for information

**EMPLOYEES' STATE INSURANCE CORPORATION
DECLARATION FORM**

I/we.....S/D/W of.....do hereby declare that I/we, am/are the only legal heir(s) or legal representative(s) of the deceased Shri/Shrimati.....(name of deceased) of..... (last address)

2. I/we hereby claimbenefit due to the deceased at the time of his/her death under Section 71 of the ESI Act.

3. I/we hereby authorise Shri..... S/W/D of..... who is also one of the legal heirs of the said deceased and whose specimen signatures are attested below to receive the above benefit under Section 71 of the Act, on behalf of all of us and we hereby declare that his receipt shall be valid discharge to the Corporation so far as we are concerned.

4. I/we hereby undertake to repay forthwith on demand by the ESIC and without demur any sum to which it is discovered at any time we are not lawfully entitled or which is discovered at any time to be in excess of the amount due to me/us and the decision of the ESIC as to the amount so to be repaid shall be final:

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | |

Specimen signature of person authorised to receive amount due

Signature or thumb impression of the claimant(s)

- N. B.
- Strike out words not applicable
 - In case applicant is a minor, the declaration would be signed by the guardian who may state below his signature as "signed for.....(being his/her guardian)
 - To be completed only when there is more than one claimant and payment is to be made only to one of them on behalf of all the legal heirs.

Attested that the above statement is made before me and is correct to the best of my knowledge and belief.

Signature & Seal of Attesting Authority

- N. B. Attestation of this form shall be admissible only from an officer of the revenue, judicial or magisterial department or a service pensioner or the head of a gram panchayat under his seal or rubber stamp.

INDEMNITY BOND

Whereas Shri/Smt.....an insured person/dependent being * s/d/w of late Shri..... an insured person under the Employees’ State Insurance Act, 1948, having Ins. No.....died on And whereas a sum of Rs..... in words Rupees towards Benefit is due and payable to Shri/Smt..... the legal heirs of the above said deceased insured person. And, whereas Shri/Smt.....the aforesaid legal heirs of the aforesaid deceased insured person has/have applied to receive the said amount as such heirs and there is no legal impediment in paying the amount to me/us. Now, therefore, in consideration of the above-said amount of Rs.....being paid to me/us by the Regional Director, Employees’ State Insurance Corporation (hereinafter referred to as “the Corporation”), I/We hereby bind myself/ourselves to indemnify the Corporation against all actions, claims and demands made and all actions and proceedings taken against the Corporation on account of the payment of the aforesaid amount to me/us.

And I/We agree that the Corporation may, without prejudice to any other rights or remedies that may occur or may be available, recover the amount of loss sustained by the Corporation with such charges as may have to be incurred as arrears of land revenue.

I/We agree that the decision of Regional Director of the Corporation about the loss sustained by it and charges to be incurred will be final and binding upon me/us.

I/We also agree that this indemnity bond shall be irrevocable.

In witness whereof I/We..... have signed at on.....

Before me

Signature or left/right hand thumb
impression of the claimant

Signature with official rubber
stamp of Magistrate

Note: If the claimant is illiterate or does not understand the English language or signs in the language other than English an endorsement from a responsible person such as a Magistrate, an advocate or an employer, to the effect that the contents are explained to the claimant in the language known to him, is necessary.

* Delete what is not applicable

SURETY BOND

(1) Shri.....aged.....years,
residing at.....Profession

(2) Shri.....aged.....years,
residing at.....Profession.....

We hereby declare ourselves as sureties of the above said Shri/Smt.....and declare that he/she/they shall do and perform all that he/she/they has/have withdrawn to do and perform and in case of his/her/their making default therein, we hereby bind ourselves jointly and severally to indemnify the Employees' State Insurance Corporation (hereinafter referred to as the Corporation) against all actions and proceedings taken against the Corporation on account of the payment of the said amount to the said legal heirs and we agree that the Corporation may, without prejudice to any other rights or remedies that may occur or may be available recover the amount of loss sustained by the Corporation with such charges as may have to be incurred as arrears of land revenue.

And we agree that the decision of the Regional Director of the Corporation about the loss sustained by it and charges to be incurred will be final and binding upon us. We also agree that this bond shall be irrevocable.

Date.....

Signature of the Solvent Sureties

Place.....

1.....

2.....

Witness:

1.....

2.....

Before me.....

Signature of the Magistrate.

Seal of the Court

(Note: as per Indemnity Bond)

CHAPTER IV

TEMPORARY DISABLEMENT BENEFIT LAW (OTHER THAN OCCUPATIONAL DISEASES)

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CHAPTER IV
TEMPORARY DISABLEMENT BENEFIT LAW
(OTHER THAN OCCUPATIONAL DISEASES)

Employment injury defined

L.4.1 Employment Injury is defined in Section 2(8) of the Act as under : -

“Employment Injury means a personal injury to an employee caused by an accident or an occupational disease arising out of and in the course of his employment, being an insurable employment, whether the accident occurs or the occupational disease is contracted within or outside the territorial limits of India.”

What constitutes an Employment Injury?

L.4.2. Employment injury should thus satisfy all the following conditions : -

- (i) a personal injury to an employee
- (ii) caused by an accident or by an occupational disease,
- (iii) arising out of employment of the employee in a covered factory or establishment, and
- (iv) arising in the course of his employment in a covered factory or establishment.

The site of the accident is immaterial and accident occurring or an occupational disease contracted even outside the territorial limits of India can result in entitlement to benefit under the E. S. I. Act.

Personal Injury

L.4.3 The first essential condition of an employment injury is that personal injury must have been caused. The term ‘personal injury’ is somewhat wider than physical or bodily injury but does not include an injury to the belongings or reputation of the person. It covers any physiological injury, for example, a man suffering nervous shock or insanity as a result of witnessing a terrible accident might be regarded as suffering from personal injury. An emotional impulse, however, does not constitute an injury unless it is accompanied by some physiological injury. Further, compensation is payable for the result of the injury and not for the injury itself. Thus, a man who suffers from shock would not get compensation unless the shock results in his being disabled.

Accident

L.4.4. The second essential condition is that the injury must arise from an ‘accident’ or by an ‘occupational disease’. There are two elements that must be present to constitute an accident : -

- (a) It must be an unforeseen occurrence; and
- (b) It must be sudden.

L.4.5. As regards (a), an accident has been defined as an unlooked for mishap or untoward event which is not expected or designed. An event which has been intentionally brought to pass by the man who suffers from it or is expected by him is not an accident. The phrase ‘by accident’ is equivalent to

‘accidental’ and implies something unexpected. Whether the occurrence is unforeseen or not is to be judged from the point of view of the injured person himself. It has also been held that an injury designed by some person other than the workman is accidental if it is not foreseen by the workman.

L.4.6. An injury, if it is self-inflicted or injuries inflicted with the consent or on the instigation of the person injured cannot form the basis of valid claims for compensation because the injury cannot possibly be held to have arisen by accident. Thus, suicide does not amount to accident. Where, however, suicide is the result of insanity which followed injury by accident, it may be held to be caused by accident. But if the suicide is due to brooding over the accident it cannot be said to be caused by accident.

L.4.7. The second characteristic of an accident is that it must be sudden. So, a gradual process cannot constitute an accident. The legislature has inserted the words ‘by accident’ in order to exclude the right to compensation for injuries not caused by sudden and untoward event, except in case of occupational diseases for which there is an express provision in the Act. The contracting of an ordinary disease is a personal injury but it is not accepted as an accident unless a definite date and place can be assigned to the infection which caused it. Occupational diseases are, however, on a different footing and are dealt with separately in Chapter IVA.

However, if an employee working under the orders of his employer dies of sunstroke, or an employee working in exposure to cold and dampness under the orders of his employer contracts rheumatism, it can be termed as an accident.

L.4.8. Combining the effect of what has been stated, an accident may be described as a ‘sudden mishap, which is not expected or designed by a workman’. It should be noted that the mishap may be external or internal. A workman who sustains a rupture as a result of lifting a heavy weight meets with an accident quite as much as the workman who has his foot crushed by the fall of a beam.

L.4.9. The fact that the occurrence would not have caused any injury but for some pre-existing weakness or defect inherent in the workman himself is immaterial. It is also immaterial that the occurrence would not have led to the death or incapacity in a stronger person.

L.4.10. A series of tiny accidents each producing some unidentifiable results and operating cumulatively or producing the final condition or injury, may constitute together an accident. Thus, where in the course of performance of his duties the eyes of a workman were exposed to the glare of the furnace and on each occasion they were struck by ultraviolet rays which they absorbed, impairing and affecting his vision in slight imperceptible degrees, till at last the gradual worsening condition reached a stage of serious defect of vision, it was held that the workman suffered personal injury, viz., the affecting of his eyes, caused to him by an accident, as also deafness caused by a sudden explosion or due to repeated noises suffered while at work. Deafness has now been included as an occupational disease in the Third Schedule to the Act. However, the nature of series will be important. Another important factor to be considered is the period of time over which it occurred. If a particular condition arose over a short period it might be termed as accident. In these cases the border-line between accident and process is at its thinnest. Thus, in England where a trainee nurse at a day nursery developed infantile paralysis after constant touch with a child suffering from it, she was held to have suffered an accident.

L.4.11. A few typical cases so as to explain ‘personal injury’ and ‘accident’ are quoted below :

Nervous Shock

- (1) A nervous shock was caused by the excitement and alarm resulting from a fatal accident to a fellow workman while engaged in the employment. Held: it was a case of personal injury by accident arising out of and in the course of employment.

Exposure to heat, cold etc.

- (2) An electrician in a press had, in the course of his duties, frequently to go into a heating room and from there to a cooling plant where the temperature was kept considerably low. One night when he went into the cooling room he got pneumonia and died of the disease. Held: the injury was caused by accident arising out of and in the course of employment.

Strain

- (3) A workman employed to turn the wheel of a machine, by an act of overexertion, ruptured himself. Held: he suffered an injury by accident (Fenton vs. Thorbay & co. Ltd., 1903). Incapacity or death as a result of strain due to lifting heavy weights comes within the purview of accident. It is not necessary to establish that there was any exceptional strain on that particular day. If it could be established that incapacity or death was due to strenuous work the employee was doing, his incapacity/death would come within the purview of the accident.

Crime and Violence

- (4) A cashier, while travelling in a railway carriage to a colliery with a large sum of money for making payment to his employer's workmen was robbed and murdered. It was held that the murder was an 'accident' from the stand-point of the person who suffered from it and arose out of an employment which involved more than ordinary risk. Assault by co-worker is an employment injury if the risk is incidental to employment.

Acceleration of a disease

- (5) When death or incapacity of a workman is caused by acceleration of disease already existing, due to an accident, the death or incapacity will be deemed to have resulted from the accident. But when the incapacity or death results from the disease itself, independent of the accident, the workman or his dependants, as the case may be, will not be allowed compensation (Mangal Chand Vs. Mumtaz Begam, 6 D. L. R (Nagpur) 166-1951).

Course of employment

L.4.12. The third fundamental condition is that the injury must have occurred in the "course of employment" of the injured person. Employment does not mean the same as 'engagement'. Employment has got broader meaning than 'work'. The main question by which it can be decided that the accident arose in the course of employment is that of duty. If, when the accident occurs, the workman has any duty to his employer or if in any way he is subjected to the employer's control, he will normally be acting in the course of his employment. Men may be acting in the course of their employment even when they are not actually working. A workman is acting in the course of his employment when he is engaged in doing something in discharge of his duty to his employer directly or indirectly imposed upon him by his contract of service.

L.4.12A. The following would be deemed "in course of employment" :

- (i) A workman has reached the place where he carries on his work and the time is such that he may be reasonably expected to be there on account of his work. Thus, if a workman is in the employer's premises and preparing for work i. e. getting out his tools, wearing of uniform prescribed for his work by the employer, he would be in the course of employment.
- (ii) If the workman is specially sent by his firm by a prescribed route to a place some distance from his usual place of work to carry out a job, the journey undertaken will be a part of his duty and in the course of his employment.

Commuting Accidents

L.4.12B. By the addition of Section 51E to the Act, effective from 1.6.2010, an accident occurring to an employee while commuting from his residence to the place of employment for duty or from the place of employment to his residence after performing duty, is to be deemed to have arisen out of and in the course of employment if nexus between the circumstances, time and place in which the accident occurred and the employment is established.

Interruption in the course of employment

L.4.13. So long as a workman is upon the premises where he is employed, the course of employment is not interrupted by break in work for purpose of rest, refreshment, or like, which may be regarded as incidental to the work.

L.4.14. A workman who is idle because he has run out of material, or because there is nothing special for him to do at the moment, or because the machinery has broken down, is still acting in the discharge of his duty, and is consequently in the course of his employment. "They also serve who only stand and wait" is sound law in cases of this kind. The same applies to a workman who interrupts his work for any necessary purpose, e. g., getting a drink. A drink at intervals is necessarily included in the terms of his employment and it is taken to enable the workman to carry on with his job.

L.4.15. If a rest interval is spent on the premises, whether it is occupied in remaining idle or in taking food, there will be no break in the employment. While the workman is on the premises, he is subjected to the control of the employer as a general rule, and can be called on at any time to carry out some order.

L.4.16. But if the workman leaves the premises (where he is employed) for his own purpose (for example, for rest, refreshment or to fetch something for his purpose) and thus goes altogether beyond the employer's control, he is not entitled to the statutory protection once he is off the premises and their means of access. Thus, where a workman was run over while crossing a public road to get milk for his tea, and where the engineer of a steam-trawler in dock went ashore for dinner and on returning fell into a dry dock, and was killed and where a worker on night shift left the premises to get supper and was injured on the way, it was held in all these cases that the workman was not protected.

L.4.17. A workman who visits the pay office for the purpose of drawing his pay is acting in the course of his employment when he is on the employer's premises for the purpose. Not only is the drawing of his pay a necessary part of the employment, but he is acting under the employer's direction in so presenting himself. But a railway officer who received a cheque and was injured while on his way to the bank to cash it, would have no claim to compensation. It was no part of his duty to the company to go to the bank when he did, or to go by the way he did, or when he did, or even to go at all. The mere fact (and this is important as it applies generally to all cases of this type) that a workman would not have been in the place where he was injured had he not been employed is not sufficient to give him a claim; he must show that his employment took him to that place, that it exercised, as it were, a measure of compulsion on him with regard to his movement at the time.

L.4.18. However, the mere presence of the employee at the place of accident not related to employment does not bring him within the course of employment. For instance, if a substitute (badli) worker comes to the time office of factory to enquire about work for himself but is refused work and if while on the factory premises is injured he cannot be said to have met with the accident during the course of employment.

L.4.19. If a workman sleeps during the course of his employment, the same is temporarily suspended.

L.4.20. However, if a workman is sent on outdoor duty, his course of employment does not break till he reports back from that assignment. The injury sustained during that period, in the absence of evidence to the contrary, shall be an injury arising out of employment.

Accident to workman at his residence provided by the employer

L.4.21. An employer may provide to his workmen houses which they are free to rent or not as they choose. In such an event, the course of employment does not extend to a workman's residence provided by his employer. But, if it is an express or implied condition of employment, that the employee should live in a house provided by the employer, and is living in the house for the purpose of his duty so that he can be on call, if necessary, or can render some service, if an emergency arises, the workman will be in the course of his employment while he is in the house and while he is moving between the house and his work. This applies, for example, to a station master living in quarters adjoining the railway station, or to a gate-keeper living at a level crossing, or to men who are assigned with quarters with a view to protection of the employer's premises against thieves or fire. But if the employee lives in the employer's house not because of any duty but because there happens to be nowhere else where he can conveniently live, as in some industrial settlements in India, he is not in the course of employment while he is living in that house. The course of employment in a case like this does not extend to his leisure hours at home. The fall of the roof of house on the workman would be an accident arising out of his employment, but would not arise in the course of his employment. The same considerations apply where the workman lives in a house because the employer provided it free, so long as there is no duty associated with its occupation.

Arising out of employment

L.4.22. The other fundamental criterion for determining an employment injury is the principle of "out of employment". Whereas, in considering the meaning of "the course of employment", regard has to be had to the circumstances in which the accident arose, in deciding the phrase 'arising out employment', the important question is the cause of the accident. To put it simply, the accident, if it is to come within the meaning of the phrase, must be in some way due to the employment. It has been said that 'arising out of employment' is an expression which "applies to the employment as such—to its nature, its conditions, its obligations and its incidents. If by reason of any of these, the workman is brought within the zone of special danger and so injured or killed" the words apply. Or more briefly, when a man runs a risk incidental to his employment and is thereby injured, then the injury arises "out of employment".

L.4.23. Section 51-A of the Act has made an important departure from the foregoing principle. It states that an accident arising in the course of a person's employment shall be presumed, in the absence of evidence to the contrary, also to have arisen out of the employment. Thus, once it is established that the accident happened during the course of employment there would be valid presumption in favour of the employee that the accident also arose out of his employment. Conversely, where there is an evidence to show that the accident did not arise out of his employment, the presumption in favour of the employee is no longer valid and has to be considered together with the other evidence available in the case. "Evidence" here does not mean merely speculative inference. "Evidence" has been stated to be information given personally or drawn from documents to help establish a fact.

L.4.24. In actual practice it would have to be considered first whether an accident happened in the course of the employment and if this is established, it will in most cases be unnecessary to enquire further whether the accident arose out of the employment, unless there are circumstances which give rise to doubt as to whether it arose out of employment.

L.4.25. "Evidence" in the sense of the Section is not the same thing as "proof" (a proof is spoken or written legal evidence to establish facts whereas evidence is information given personally or drawn from documents tending to establish a fact). It may also be noted that the words of the Section are not "in the absence of proof to the contrary" or "unless the contrary is proved" but "in the absence of evidence to the contrary" which means that if there is evidence before the Corporation that the accident did not arise out of or in the course of employment, there is no presumption at all and it is left to the parties to prove the case in the ordinary way.

Decided cases – out of employment

L.4.26 (1) A hospital stoker who was in the night shift was found dead the next morning. He was lying on the floor of the mess room adjoining the gas house with his head pillowed on a rolled-up coat. The gas was escaping from a gas ring and death was due to carbon monoxide poisoning. It was in evidence that the deceased had lain down for a nap. It was also in evidence that it would be breach of duty for a stoker to sleep during the shift. Held : In going to sleep, the deceased had removed himself from the course of his employment, that there was certainly evidence to the contrary in the present case and so the presumption in favour of employee disappeared. (It may be noted that Section 51-B also does not apply in this case as the deceased's act of lying on the floor was not for the purposes of his employer's trade or business). The claim was disallowed.

(2) A postal employee was repairing a fault in a telephone call box when a young man opened the door to the box. The postal employee remembered nothing more until he arrived home bleeding from a head wound. The claimant suffered loss of memory also. Held: "Evidence" in the sense of the Section means something more than speculative inference and that if there was no evidence that the accident did not arise out of the applicant's employment, the Section applies and the accident is deemed to have arisen out of employment. The claim was allowed.

"Out of employment" clarified

L.4.27. The term "arising out of employment" embraces the following clarifications : -

- (a) 'Employment' includes character, conditions, environment, incidents and special risks of work.
- (b) Accidents due to environment or material surroundings of the employee e. g. contact with plant, machinery, breaking of metal, collapse of wall, roof etc., arise out of employment.
- (c) An accident to a workman obliged to work in a place with special risk or danger to which his presence exposes him arises out of his employment.
- (d) An assault by a co-worker in a dispute unconnected with employment does not arise out of employment.
- (e) An accident to a workman who is injured while obeying in good faith the order of one competent to give him orders, even if the superior has acted improperly and contrary to employer's instructions, is deemed to have arisen out of the workman's employment.
- (f) Accidents arising from horse-play do not usually arise out of employment.
- (g) An accident arising from an act done in performance of one's duties clearly arises out of employment, however recklessly the act itself may be done.
- (h) An accident from an epileptic fit or other fit does not arise out of employment unless proximity to place of work renders consequence of the fit dangerous, e. g., a fall on a moving machine or on a hard concrete floor resulting from an epileptic fit.
- (i) An accident due to assault by another person whether a co-worker, employer or a stranger does not arise out of employment unless the workman is obliged to work where such assault was a special risk or the quarrel leading to assault was not provoked by the workman and arose out of his devotion to duty.
- (j) An accident to a workman sent out on his employer's business whether regularly or occasionally, whether on foot or by any reasonable means of conveyance, caused by the street risk to which he is exposed, arises out of as well as during the course of his employment even

though the risk which caused the accident was shared by all members of the public using the street under like conditions, provided the workman was present on the spot of the accident in his capacity as a workman (viz., in pursuance of his duty towards his employer) and not as a member of the public (i. e., of his own volition unconnected with his duty to his employer).

- (k) An accident to a workman by an act of God or natural calamity, e. g., lightning, flood, etc., may be deemed to have arisen out of his employment only if it is also proved that the place where he worked, exposed him to a special risk. As an illustration, lightning striking a workman working on a high chimney would arise out of his employment, which will not be so if lightning strikes one who works in a street below.
- (l) Non-employment acts need to be examined on merits whether the accident therefrom arose out of employment. Example: A lady was injured while taking bread which contained glass pieces. The catering had been arranged by the employer and workmen were provided refreshments at the place of work. Held: There was sufficient connection between the employment and the injury.

Circumstance vs. cause

L.4.28. According to its definition, ‘Employment Injury’ is a personal injury caused by accident arising out of and during the course (the circumstance) of employment. Section 51-A says that an accident occurring during the course of employment shall be deemed, in the absence of evidence to the contrary, to have also arisen out of employment. Thus, every accident must occur during the course of employment and the rest follows only thereafter. Here is a case which appears to be not only an exception but something just the opposite, i. e., an accident arising out of employment but not during the course of it. A supervisor during a weekly off was shopping with his family in the local market when he was attacked and fatally injured by two of his workmen. The motive of the attack was their dispute with the supervisor over work allocation in the factory. Apparently the supervisor’s accident arose out of his employment but not during the course of it. But, on a closer look, it will be observed that there is a direct causal relationship between his employment and his injury and hence a case of this type has to be deemed as not only having resulted from his employment (the cause) but also during the course of it (the circumstance).

‘Added Peril’

L.4.29. When a workman does something which was no part of his employment to do and thereby incurs a risk to which he was neither required nor authorised to expose himself, an accident caused thereby will not arise out of employment. In other words, if the workman is injured by exposing himself to what is known as an ‘Added Peril’ he is not entitled to compensation.

L.4.30. The phrase ‘Added Peril’ has been defined as a peril voluntarily super-induced on what arose out of the employment and cumulative to it; to which the workman was neither required nor had the authority to expose himself. A distinction has to be drawn between a workman performing his duties in a rash or negligent manner and “arrogating to himself duties which he was neither engaged nor entitled to perform”. A workman does not forfeit compensation by doing his own work in the wrong way; but if he does something different in kind from his duty, an accident so caused is not incidental to his employment and, therefore, does not arise out of it. When a piecer in a cotton mill lost his arm through interfering with the tin roller under the table, and it was clear that his duties did not involve anything of the kind, compensation was refused. Again a workman who, out of curiosity, gets a fellow-workman working a new machine to allow him to operate it, is not entitled to compensation. An accident sustained by a workman in attempting to steal oil from bearings, or in rubbing coal from pillars instead of taking it from the coal face where he has been set to work does not arise out of the workman’s employment.

Act outside the sphere of employment

L.4.31. An employee acts outside the scope/sphere of his employment when he does something which is not part of his job and which is different in kind from anything he is required or expected to do.

He arrogates to himself that which he was neither engaged nor entitled to perform under terms of contract of service as well as the purpose of his engagement determining the scope of his duty.

But the sphere of duties may be enlarged by orders from superiors. As a general rule, the fact that a claimant is doing something which his foreman has ordered him to do is sufficient to prove that an accident which occurs while so acting arises out of employment.

Illustrations:

- (1) Where a man who was to stack sacks by manual labour used a rope and a revolving shaft and was injured, his accident did not arise out of employment.
- (2) Where a girl was employed on a hand press, took it on herself to work at a power press and was injured, she did not suffer an employment injury as the injury did not arise out of employment.
- (3) An assistant porter working under the direction of the head porter took it upon himself to dust the top edge of a moving lift and met with an accident, he did not get any compensation as this accident did not arise out of employment.

Prohibited Acts.

L.4.32. Where an employer expressly forbids certain acts but the workman ignores the prohibition and is injured while acting in violation of the prohibitory order, the accident does not arise out of and during the course of employment.

L.4.33. While investigating a case of accident falling in any of the types mentioned in the foregoing paragraphs, great caution needs to be exercised by an investigating official because a mere theoretical application of the principle above enumerated may cause great hardship to persons sustaining injuries from accidents occurring in extenuating circumstances beyond the control of those persons. This is because practice or usage existing in a certain workplace may point to a direction different from rejection of the case. Hence, before giving his recommendations in cases of the above three types, the investigating official should also address himself to the following questions and find answers thereto :

- 1) What are the normal duties of the workman?
- 2) Has the sphere of duties of the workman been clearly defined by the employer and the employer produced a copy of the same?
- 3) Was there a prohibitory order served on the injured person and were its implications clearly understood by him? Has the employer produced a copy of the same order?
- 4) What exactly was the workman doing at the time of the injury?
- 5) Had someone ordered him to do what caused him the accident?
- 6) Was his alleged act of over-stepping his sphere of duties or prohibitory order in accordance with an established practice?
- 7) Has the employer been ignoring in the past in the case of this and other workmen what this workman was doing at the time of his injury even though prohibited by standing orders?

An answer in the affirmative to question 5, 6 or 7 above will, by and large, make the case as one of employment injury. However, a decision as to whether it is or it is not a case of employment injury will rest on the merits of each individual case.

Accidents while acting in breach of regulations, etc.

L.4.34. Section 51-B of the Act runs as under : -

“51-B. An accident shall be deemed to arise out of and in the course of an employee’s employment notwithstanding that he is at the time of the accident acting in contravention of the provisions of any law applicable to him, or of any orders given by or on behalf of his employer or that he is acting without instructions from his employer, if –

- (a) the accident would have been deemed so to have arisen had the act not been done in contravention as aforesaid or without instructions from his employer, as the case may be; and
- (b) the act is done for the purpose of and in connection with the employer’s trade or business”.

L.4.35. Under Section 3(1) of the Workmen’s Compensation Act, a workman’s claim for compensation is defeated, except in case of injuries resulting in death or in permanent total disablement, if the accident was directly attributable to his being under the influence of drink or drugs or to his wilful disobedience to an order/rule expressly given/framed for securing the safety of workmen or his wilful removal or disregard of safety guard or other device which he knows to have been provided for the safety of workmen. A parallel provision does not exist in the ESI Act and hence no question of ‘wilful disobedience’ or ‘wilful removal or disregard of any safety guard or other device’ arises under the ESI Act. Section 51-B on the other hand helps a protected person to obtain compensation if conditions laid down therein are satisfied despite the fact that he acted at the time of accident, in contravention of the provisions of any law applicable to him or of any orders given to him or he acted without instructions from the employer.

L.4.36. The conditions (a) and (b) of Section 51-B are cumulative and not alternative. In other words, the accident must be one which would have arisen in any case despite the contravention or lack of instructions. Further, as per (b) of Section 51-B, there is a pre-condition that the act leading to the accident should be within the scope of employment of the employee, for if the act itself is beyond the scope of employment of the employee, it cannot arise out of it. This Section does not extend the scope of employment of an employee. If the act in question giving rise to the accident, whether prohibited or not, was different in kind from what the employees was employed to do, then the effect of Section 51-B cannot be to bring it within the scope of his employment. In that event, the direct and simple way of answering the question would be that the employee was not doing his employment at all or was doing something for which he was not employed at all. Such an act cannot possibly be held to have been for the purpose of employer’s business. However, if the act was done in an unauthorised or forbidden manner, the Section comes into play and assists the employee if the act was a part of his employment.

L.4.37. This Section means that if a person is doing something which lies within the scope of his employment but is doing it in a prohibited way or without instructions, the prohibition or the lack of instructions will not serve to defeat his claim.

L.4.38. A person indulging in an unauthorised experiment for satisfying his own curiosity and not at all for the purpose of his employer’s trade or business is not protected by this Section.

L.4.39. While sub-section (a) of the Section would be satisfied or waived, if the act is done in opposition to or without instructions from the employer, no such presumption arises in favour of the employee in sub-section (b) which requires that the act which caused the injury must be an act for the employer’s trade or business.

L.4.40. It may be noted that the Section applies only to acts done after the course of employment has begun and before it has ended. If the accident occurs at a time when the employee has not yet entered upon the course of his employment or the course of employment has terminated, the Section does not apply.

Decided cases

L.4.41. A porter injured his leg when he slipped into a shallow pit after hanging his wet apron in a recess near the ovens. The claimant had been forbidden to hang anything near the ovens. For hanging the aprons, a small hook had been provided in the kitchen. It was held that both the conditions of the above Section had been satisfied. Condition (a) was held to have been satisfied as except for the prohibition to hang anything near the ovens, the claimant's act of hanging apron in the recess would certainly have arisen out of and in the course of his employment. Condition (b) was also held to have been satisfied as the act was held to have been done for the purpose of and in connection with the employer's trade or business as the provision of hooks in the kitchen showed that the act of hanging up aprons was undoubtedly an act done for the purpose of the employer's business.

L.4.42. A canteen assistant was entitled as a part of her remuneration to a free meal to be taken in another nearby canteen also run by the employer. After taking a meal in the other canteen, while walking back to the canteen where she was employed she slipped and was injured. She was using a short cut alleged to be forbidden. It was held that in going to and from the canteen, she was not merely taking advantage of permission afforded by her employer but was doing an act in fulfilment of her contract of employment and it was a part of her employment to travel to and from the canteen to take her meal. The risk incurred while travelling was held to have arisen out of her employment. If the use of the short cut was forbidden, the above section enabled the accident to be deemed to have arisen out of employment.

L.4.43. The claimant was employed as a driver but was also engaged at different times as a holeborer. One day when he had been directed to the work of holeboring, he took over driving from a fellow workman and while driving met with an accident.

It was held that driving was within the scope of the employment of the claimant. In the present case it was admitted that the claimant's act of driving was not directly prohibited. Even if the act of driving on the occasion was without instructions from the employer, the claimant would have succeeded by virtue of the above section. The act of driving being for the purpose of and in connection with employer's trade or business, the accident would have been deemed to have arisen out of and in the course of claimant's employment had the act not been done without the instructions of the employer. The above Section was held to apply and the claim was upheld.

L.4.44. The claimant was required to work at a depot 10 miles from his normal place of work. While the employer normally provided transport to bring his employees back from the depot to their place of work, the employees had to make their own arrangements for returning to their place of work when the employer's transport did not arrive. The transport was expected at 4:30 P.M. to pick him up and after waiting till 5.00 P.M., the claimant started walking along the public road to meet the lorry. While so walking, he was run over by another lorry which did not stop.

It was held that even though in leaving the depot, the claimant was acting without instructions, he was acting for the purpose of, and in connection with, his employer's trade or business and so his case was covered by the above Section. The claim was allowed.

L.4.45. A dock worker met with a fatal accident while driving a truck which overturned and fell into the water. He was not authorised or permitted for the purpose of his work to drive the truck. It was never one of his duties to drive or handle the truck. It was held that the above Section did not help the workman and it does not extend the scope of an insured person's employment. The accident was held not to have arisen out of and in the course of employment of the worker.

Act in accordance with usage or practice

L.4.46. When a workman is injured while acting in accordance with a recognised usage or practice he would be protected even though his act might be outside the scope of his employment, Examples: —

- (1) The deceased was employed in an electric supply company to put and change posts and to connect and disconnect wires. On the day of the accident the deceased, while returning from his work, stopped to help other workmen employed to do the same work and met with death while so helping. Such helping was customary and without objection by the employer. It was held that the accident arose out of and in the course of the employment.
- (2) A Carter driving towards his employer's yard in the course of his employment was asked by a fellow workman going in the same direction for a lift. He consented, and stood up to fix a seat at the back of the cart. The horse suddenly moved on and he over-balanced, fell off, and was killed. There was evidence that the employer knew of and permitted the practice of giving lifts. It was held that the accident arose out of and in the course of the employment.
- (3) A brick-layer employed in the erection of a large mill was being carried up to his work, with two others, in a hoist, which had been installed for the purpose of lifting materials, when the chain broke and precipitated them to the ground. It appeared from the evidence that the employer told the men to use the staircase and not to go up in the hoist, but the prohibition was generally disregarded, even by the foreman, whose duty it would be to enforce it, and the hoist was constantly used by many of the men. It was held that the accident arose out of the employment.

Ambiguous instruction

L.4.47. A workman's sphere of employment cannot be restricted by a nominal prohibition which is not enforced by the employer or his officials. It can also be not restricted by an order which is ambiguous and is misunderstood by the workmen.

Workman acting for own purpose

L.4.48. Where the workman, though during a time when the course of his employment is subsisting, does something entirely for his own purposes and thereby incurs a risk which causes an accident, he is not entitled to compensation. The mere fact that the accident has happened on the employer's premises is immaterial.

Example: A workman incharge of a printing machine injured his hand while placing a tin of condensed milk on a ledge in the machine immediately below the running machinery. The practice of keeping things for tea in this place had existed for a long time, but was kept entirely a secret to prevent pilfering by other workmen. Held: the accident did not arise out of the employment

Accident happening while travelling in employer's transport

L.4.49. Section 51-C of the Act reads as under : -

“51C(1) An Accident happening while an employee is, with the express or implied permission of his employer travelling as a passenger by any vehicle to or from his place of work shall, notwithstanding that he is under no obligation to his employer to travel by that vehicle, be deemed to arise out of and in the course of his employment, if –

- (a) the accident would have been deemed so to have arisen had he been under such obligation; and
- (b) at the time of the accident, the vehicle
 - (i) is being operated by or on behalf of his employer or some other person by whom it is provided in pursuance of arrangement made with his employer, and
 - (ii) is not being operated in the ordinary course of public transport service.

(2) In this Section 'vehicle' includes a vessel and an air craft."

L.4.50. Section 51-C makes a special provision for cases where person travels to or from his place of work in a vehicle other than a public transport vehicle, which is operated by or on behalf of his employer and in which the employed person has the employer's express or implied permission to travel, even though he is not obliged to travel in it. Under this provision, the fact that the use of vehicle is entirely optional no longer prevents the insured person from recovering compensation. All that is required is that there should be the express or implied permission of the employer. This is a question of fact in each case. Permission may arise from words spoken by the employer, from notices put up in the place of work stating that transport will be provided, from the fact that the employer provides transport or from the fact that the employer knowingly acquiesces in his employees travelling in some vehicle such as the car of a fellow-servant or a vehicle provided by an employer at another factory, provided that it is not a public service vehicle

L.4.51. The words "travelling as a passenger by any vehicle" extend the course of a person's employment to cover a period of travelling as a passenger, which includes the act of boarding and alighting and waiting inside the vehicle for it to start, but does not cover the act of walking towards the vehicle before boarding or of walking away from it after alighting. In other words, the course of employment is extended to cover an accident which happens while travelling as a passenger but does not extend so as to cover an accident when an employee is due to become a passenger or is no longer a passenger.

L.4.52. The words 'not being operated in the ordinary course of public transport service' have to be interpreted with reference to the facts of each case. "Public transport service" is a general phrase, intended to cover all forms of public conveyance, but the word "service" connotes some sort of regular schedule of operations. The words "ordinary course" exclude the right of benefit where the employee is travelling as a member of the public, availing himself of the ordinary service provided for the public but do not exclude benefit in a case where the transport, though provided by a public transport service organisation, such as a bus company, is a special vehicle provided by arrangement and not part of their regular service provided for the public. Even while travelling by a public transport service the employee shall be entitled to benefit, if the facts establish the following :-

- (a) The vehicle was restricted to the workmen only on the occasion and place in question, that is, on that occasion and place, the public were not permitted to be carried but only workmen travelling to and from their work. The vehicle cannot be said to be operated in the "ordinary course" of a public transport service at least on such occasion and place.
- (b) The service is not published in the ordinary passenger time-tables.
- (c) The service discontinues when factory is closed.
- (d) The vehicle bears no destination indicator.

L.4.53. The purpose of Section 51-C thus is to extend the scope of a person's employment beyond the confines of his place of work so as to include the vehicle which carries him to and from the work when the conditions laid down in the section are fulfilled. A person is deemed travelling as passenger by a vehicle to his place of work even though the vehicle stops short of the place of work and the person will have to complete his travelling by some other means-perhaps on foot or perhaps by some other vehicle. For example, where an employer sends round his vehicle to collect his workmen from their various homes and assembles them at a central point from which public transport will take them to the place of their work, the workman is travelling as passenger by the vehicle provided by the employer even though it is not intended that the vehicle shall go all the way to his place of work.

L.4.54. The term "arrangement" in the section implies something more than a mere suggestion or request, but is not confined to a legally binding contract only. In order to satisfy the term "arrangement",

there should be some measure of control by the employer evidenced possibly by reservation of the vehicle for the exclusive use of the workmen or some other facts.

L.4.55. Sub-clause (i) of clause (b) of the section covers both the cases of the employer's own vehicle such as his own car driven by himself, and of the vehicle being driven by his servant or agent. The case of an independent contractor who provided transport by arrangement with the employer would be covered under this sub-clause.

L.4.56. The provisions of Section 51-C would not cover the following cases : -

- (a) Where the employer arranges with a bus company to put extra buses not specially reserved for his employees on one of their ordinary public routes;
- (b) Where a person who was employed by a bus company goes home in one of the company's buses carrying passengers in the ordinary course of its operation;
- (c) Where a person gets a lift home in the delivery van belonging to his employer in which he does not have employer's permission, express or implied, to travel.

L.4.57. It may be noted that a person required to travel by a certain means and unnecessarily adopting a different means of conveyance, is not in the course of his employment while so doing. Further, a person who is required to perform a specific journey for the purpose of doing some work which is a part of his employment or a person of whose employment travelling itself forms a part, such as a commercial traveller, is in the course of his employment while so travelling regardless of what means of transport he adopts.

Decided cases relating to employer's transport

L.4.58. (1) The claimant was employed by his employer 'W' and travelled to and from the work daily on W's lorry the use of which was provided free of charge. Later, the claimant ceased to be employed by 'W' and obtained employment in another company which also operated at the site where 'W' operated. The claimant continued to use W's lorry as 'W' permitted the workmen of other contractors to use his lorries. 'W' informed other employers on the site of the system of issue of passes to those employers who applied for passes on behalf of their workmen. In pursuance of this arrangement the employer of the claimant was given passes by 'W' for such men as required them.

The point that arose was whether the facts sufficiently amounted to "arrangement" between 'W' and the employer of the claimant. It was held that what the Section only requires is that the vehicle should operate by some person (viz. W) by whom it is provided in pursuance of the arrangements with the employer. The arrangement here was the permission given by the employer to the claimant to use W's vehicle in pursuance of the offer made by 'W', which was sufficient to amount to "arrangement".

(2) An employee was fatally injured in an accident to the van in which he was travelling alongwith other employees after completing the day's work. They had diverged from the direct route to visit a public home for refreshments where they stayed for about an hour and then there was a further deviation for the purpose of dropping the employee at a point near his home. The duty of all the employees in the van was to return to the factory with the van. Held : The deviation from the route for the purpose of refreshments could not be held to be any part of that which the employee was employed to do or anything incidental to the performance of his duties. The above Section does not help in this case as the employee here was not travelling to or from his place of work with the express or implied permission of his employer. The employee was travelling from a public house to a point near his home and his employer had not given him any permission to do so. The claim was rejected.

- (3) The claimant was injured while travelling to his place of work by a special bus run by a public transport undertaking. As a result of verbal discussion between the factory representatives and the bus company, buses were run in the morning to take the employees to work. On working days the bus company carried other workers also but when the factory was closed on holidays etc., the bus did not run. The bus service was not shown in the ordinary passenger time-table. Held : Requirements of the above section had been fulfilled as the bus was not being operated in the ordinary course of a public transport undertaking inasmuch as only workmen travelling to and from their work were carried. The service was discontinued when the factory was closed and the service was not published in the ordinary passenger time-table.
- (4) A miner was injured while travelling from the place of work by a bus run by a public transport undertaking. The bus was operated under a road service licence and was run specially for the miners. The bus service did not appear in the public time tables. It was not the practice to stop the bus at the ordinary public bus stops. Held : Though the vehicle was operated under road service licence as a public service vehicle, it satisfied the conditions of the term "arrangement" used in the section as the employer exercised some measure of control evidenced by the reservation of the vehicle for the exclusive use of workmen. Further held : On the occasion when the claimant was injured and at the place in question, the vehicle could not be said to have been operated in the ordinary course of a public transport service. The claim was allowed.
- (5) A bus conductor who was on his way to work and was waiting at a bus stop for one of his employer's ordinary public/transport buses, was given a lift by the driver of a bus belonging to his employer, which was not at the time being used for conveying passengers. This bus was going to a depot about half way between the place where the claimant boarded it and the place of work of the claimant. While entering the depot, he fell off and was injured. It was in evidence that the practice of drivers and conductors travelling to and from duty as passengers in buses which were not in the ordinary course of public service was known to and permitted by the claimant's employer. A view expressed was that the claimant was travelling "towards" his place of work and not "to his place of work", for the depot was only half way between the place of boarding and the place of work of the claimant. Held : A person is travelling as a passenger by vehicle "to" his place even though the vehicle stops short of the place of work and the person will have to complete his remaining journey by some other mode. The claim was allowed.

Accident happening while meeting emergency

L.4.59. Section 51-D of the Act reads as under:

"An accident happening to an employee in or about any premises at which he is for the time being employed for the purpose of his employer's trade or business shall be deemed to arise out of and in the course of his employment, if it happens while he is taking steps, on an actual or supposed emergency at those premises, to rescue, succour or protect persons who are, or are thought to be or possibly to be, injured or imperilled, or to avert or minimise serious damage to property".

L.4.60. The following points may be noted in this connection :

- (1) The word "emergency" has not been defined but "emergency" has to be taken to mean something which occurs unexpectedly. It does not necessarily mean an occurrence giving rise to great danger.
- (2) The word "premises" occurring in the section includes the building and land attached to it, but does not include a public road. So far as the accident is concerned, it is sufficient for the purposes of the injured worker (claimant) if it occurs in or about the premises, i. e., including a place close to the premises.

- (3) The words “for the time being employed” include a temporary work on premises, whether the employee works for a short or a long time. For example, if a painter is employed to paint the house of a customer of his employer, the house is the premises at which the painter is employed for the time being, even though he may, in general, be employed elsewhere. Again, if a postman or the milk roundsman is on the house only for a few minutes for the purpose of his work, the house is the premises at which he is employed. The fact that he is only temporarily employed there does not matter. The concept of employment at a place suggests a duty to work there.
- (4) The section extends compensation to a person who, while working for example in his employer’s factory, takes steps upon an emergency there to rescue anyone whether employed or not or to protect property whether it belongs to the employer or not.
- (5) Again, if a person working on the premises breaks off his work on becoming aware of an emergency, he does not thereby cease to be employed at the premises, even though he goes out into the street to effect the rescue.
- (6) It may be noted that the onus is upon the claimant (employee) to prove that he was taking steps to rescue, succour or protect persons or to avert or minimise serious damage to property on an actual or supposed emergency.
- (7) The principle of “emergency” would apply even where the injured worker was not at work at the time of emergency. For example, if a chauffeur passing his employer’s house saw that it was on fire, it would be his duty, or at any rate he would be authorised to take reasonable steps to protect it from further damage. The logical view in such cases is that by taking such action, the injured worker re-enters the course of his employment. As a general rule, a servant has implied authority upon an emergency to endeavour to protect his master’s property if he sees it in danger or has reasonable ground for thinking that it is in danger.
- (8) It may frequently happen, however, that a worker injured in an emergency will be entitled to an employment injury benefit without the aid of the special provisions contained in Section 51-D, since it may well be found that he was acting within the scope of his employment. The Section covers emergency at the premises in or about which the worker is employed for the purpose of his employer’s trade or business and not an emergency on other premises. For example, if a workman goes to some other premises some distance away from where he is employed, to assist in rescuing someone trapped in a lift and is himself injured, he will not be covered by this section, but if he goes to help extinguish a fire in the neighbouring premises and it was thought likely or possible that the fire would spread to his employer’s premises, he would be covered by this section in the event of an injury.
- (9) It is not necessary that an injury should actually have happened to the person or persons whom the employee was seeking to help or that there should be any actual damage to property which he was trying to avert or minimise. It is sufficient that the employee thought the persons to be or possibly to be imperilled or that he was seeking to avert or minimise serious damage to property. The emergency may be “actual” or “supposed” and the supposition is that of the rescuer (injured employee). If the employee in fact supposed that there was an emergency, it does not seem to matter whether there were reasonable grounds for the supposition; the employee’s honest belief based on his estimate of the situation at the time of emergency is enough. Similarly, while the Section refers to serious damage to property, the serious nature of damage is according to the reasonable estimation of the rescuer; in actual practice, it will seldom be necessary to consider too closely whether the damage to property, which the injured person feared, was likely to be “serious”, since in an emergency, a person could hardly be expected to pause and weigh up the possible extent of damage that threatened. “Property” means tangible property.

- (10) The kind of action on the workman's part is not limited to actual rescue work but help in the widest sense as the words, "to rescue, to succour or protect" signify. For example, if a man goes to give a restorative or morphia to another man trapped under debris and is himself injured, this would be a case of 'succour'.

Decided cases relating to emergency

L.4.61. (1) The claimant had a fall in attempting to gain access to the factory from which the workmen were locked out as the person responsible for opening the factory had not arrived at the usual time. The claimant tried to enter through first floor window and sustained an injury. The foreman of the claimant had not instructed him to climb into the factory.

It was held that the claimant's action was not "emergency action" because it was not "something reasonable and sensible in the circumstances". There was no emergency, the object in view was not very important and the risk taken was disproportionate. The claim was disallowed.

(2) The claimant employed as a van driver normally garaged his employer's van in a garage of a hotel. He did not work on weekends. While claimant was in the hotel on a Sunday, the garage caught fire. The claimant tried to rescue the van from the burning garage and in so doing received burns.

It was held that it would be too narrow a view to hold that before the emergency arose, the claimant was not within the course of his employment. The opinion held was that the logical view was that by taking such action the employee re-enters the course of his employment. The claimant did what was reasonable in the circumstances for the protection of his employer's property and so the injury which he suffered clearly arose out of his employment and this would have been the position even if the Section had not existed.

(3) A milk rounds-man was in the process of delivering milk to a bungalow when he saw it on fire. He immediately put down the milk bottles and ran to the back of the bungalow. While attempting to rescue some children who were in it, he was injured.

It was held that the word "premises" included not only the bungalow but also the land etc. attached to it, and that therefore the claimant was in the area and about the premises when he put down the bottles and he was at the premises when the accident happened. It was also held that the claimant was for the time being employed for the purposes of his employer's trade or business at a place where he met with the accident. The claim was allowed.

Unusual cases

L.4.62. Managers and investigating officials may come across some unusual cases such as an accident where dead body was not found. It may happen that direct evidence may not be available to prove such a case as that of employment injury. A case is on record in which a truck driver was driving his truck loaded with beer bottle crates of a brewery and was trying to cross a flooded nullah as he had noticed that another truck had just passed over the bridge which was under water at that time. While trying to pass over the bridge his truck was washed away by the swirling waters and his dead body was never found even though the truck was recovered. It was held that this was a case of employment injury. In this case, it was purely circumstantial evidence which was found sufficient to treat the case as one of employment injury.

Unexplained accidents

L.4.63. Here the general principle to be applied is that if an accident is shown to have happened during the course of employment and at a place where the employee was discharging his duty of employment and the accident is capable of being attributed to a risk which is ordinarily inherent in the discharge of his duties, it can be legitimately inferred, in the absence of any evidence pointing to an opposite conclusion, that the accident arose out of employment. Example: A watchman was found dead in

the early morning hours outside the factory gate. Nobody had seen him falling or dying. It was established that he came on duty in the previous night. The case was held to be that of employment injury. In similar circumstances, the case of an engineer who was found dead outside the factory gate was not held to be one of employment injury.

Heart failure, stroke, etc., at work

L.4.64. An employee while at work may suffer a heart attack or a stroke and when it happens, the onset is often so sudden that such an attack has long been recognised in case law on the subject as an 'accident'. Obviously, such an attack comes during work, and thus it occurs during the course of employment and all that remains to be established is that it arose 'out of employment'. In such cases the presumption always is that the stress and strain of the work done by the sufferer/victim may have brought physiological changes in him and this precipitated a heart attack or a stroke. Section 51A provides that if the accident has happened in the course of employment and if there is no evidence to the contrary, it will be sufficient to hold that the accident also arose out of employment. Regional Directors have been empowered to admit such cases on the advice of the State Medical Commissioner/Medical Referee who in turn, has to place his reliance on the death certificate/post mortem report/chemical analysis report. In cases where an employee survives an attack and receives treatment in a hospital and subsequently dies, and the body is disposed of without a post-mortem examination, his diagnostic record during his stay in the hospital will be helpful to SMC /Medical Referee in coming to a conclusion whether death was due to heart attack or a stroke which might have been precipitated by physiological changes in the employee brought on by stress and strain of work.

Definition of temporary disablement

L.4.65. Discussion in the foregoing paras has centred around mainly on what constitutes an "employment injury". It will be futile to discuss details of provisions on temporary disablement benefit without mentioning what is "temporary disablement". Section 2(21) defines "temporary disablement" as "a condition resulting from an employment injury which requires medical treatment and renders an employee, as a result of such injury, temporarily incapable of doing the work which he was doing prior to or at the time of injury."

Duration of temporary disablement benefit

L.4.66. No absolute waiting days, as in the case of sickness benefit are to be observed in the case of temporary disablement benefit. But in terms of Section 51 of the Act read with Rule 57 of the Central Rules –

- (a) Where a person sustains temporary disablement for less than three days excluding the day of accident, no benefit at all is payable.
- (b) When a person sustains temporary disablement for not less than three days excluding the day of accident, temporary disablement benefit is payable from the date of commencement of temporary disablement.
- (c) The waiting period in case of a temporary disablement benefit claim need not be a continuous spell and the days to be counted should be only those days on which the insured person did not work. Once disablement for not less than three days excluding the day of accident has occurred, temporary disablement benefit becomes payable. In the context in which the expression 'not less than three days' and 'excluding the day of accident' are used in Rule 57 (1) a day does not mean calendar day from midnight to midnight but working day of the employee.
- (d) As per Section 63 of the Act as amended, no temporary disablement benefit is payable for any day on which the insured person works or remains on paid leave or on paid holiday or on which he remains on strike. [for exceptions to the foregoing, please see Para L.4.70 below].

L.4.67. Temporary disablement benefit is payable to a person during the period of such disablement, that is, so long as the temporary disablement lasts. It may be 4 days, 4 weeks, or 4 months, that is, so long as the temporary disablement has not ended, whether by cure through treatment or by turning into permanent disablement.

Conditions attached to grant of TDB

L.4.68. There is no contributory condition attached to grant of temporary disablement benefit. The following are, however, the general conditions which should be satisfied by any person claiming this benefit : -

- (a) The employment injury as defined under Section 2(8) should occur on or after the appointed day.
- (b) The injury should be sustained by an insured person while he is an “employee” within the meaning of Section 2(9).
- (c) Medical certificates to the effect that there is a condition requiring medical treatment and rendering the employee, as a result of the injury, temporarily incapable of work have to be furnished according to the provisions of the ESI (General) Regulations.
- (d) The certificates should be furnished within the time limits laid down in Regulation 64. (For details see Chapter II – Certification)
- (e) The claim should be submitted on the appropriate form.

Daily rate of TDB

L.4.69. Pl. see paras P.4.43 to P.4.49 of the procedural part of this chapter.

Persons not entitled to receive benefit in certain cases

L.4.70. Section 63 of the Act, as amended, says as under : -

63. Persons not entitled to receive benefit in certain cases.– Save as may be provided in the regulations, no person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he works or remains on leave or on a holiday in respect of which he receives wages or on any day on which he remains on strike.

This provision is absolute in case of a paid holiday or paid leave and temporary disablement benefit is not payable for these days. However, paid leave or paid holidays on which IP is certified as needing abstinence from work will be counted for satisfying the condition of a minimum of 3 days excluding the date of accident as required in Section 51 (a) of the ESI act.

As for the question of payment of benefit, for the period of strike, please see paras L.3.30.1 to L.3.30.3 of Chapter III on General Claims Law.

Benefits not to be combined [Sec. 65]

L.4.71 (1) An insured person shall not be entitled to receive for the same period –

- (a) both sickness benefit and maternity benefit;
- (b) both sickness benefit and disablement benefit for temporary disablement

- (c) both maternity benefit and disablement benefit for temporary disablement.
- (2) Where a person is entitled to more than one of the benefits mentioned above, he shall be entitled to choose which benefit he shall receive.

It follows that an insured person can receive for the same period sickness benefit and disablement benefit for permanent disablement or sickness benefit and dependants' benefit.

Recipients of sickness benefit/temporary disablement benefit to observe conditions

L.4.72. According to Sec. 64, a person who is in receipt of sickness benefit or disablement benefit (other than benefit granted on permanent disablement) –

- (a) shall remain under medical treatment at a dispensary, hospital, clinic or other institution provided under the Act and shall carry out the instructions given by the medical officer or medical attendant in charge thereof;
- (b) shall not while under treatment do anything which might retard or prejudice his chances of recovery;
- (c) shall not leave the area in which medical treatment provided by the Act is being given, without the permission of the medical officer, medical attendant or such other authority as may be specified in this behalf in the regulations; and
- (d) shall allow himself to be examined by any duly appointed medical officer or other person authorised by the Corporation in this behalf.

L.4.73. Sickness benefit or temporary disablement benefit may be suspended if a person who is in receipt of such benefit fails to comply with any of the requirements of Section 64 of the Act and such suspension shall be for such number of days as may be decided by the authority authorised by the Director General in this behalf. For details refer to Chapter – III – General Claims Procedure.

Compensation for disease other than occupational disease

L.4.74. In so far as any disease other than the diseases specified in the Third Schedule is concerned, no disablement benefit is payable to an employee unless the disease is directly attributable to a specific injury by accident arising out of and in the course of employment. It would, therefore, be necessary in case of such other disease to prove that the disease constitutes an accident within the meaning of the word [and not within the special meaning of Section 52A(1)], that the accident arose both out of and in the course of employment and that the disease was directly attributable to a specific injury sustained in that accident.

CHAPTER IV
TEMPORARY DISABLEMENT BENEFIT PROCEDURE
(OTHER THAN OCCUPATIONAL DISEASES)

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CHAPTER IV

TEMPORARY DISABLEMENT BENEFIT PROCEDURE (OTHER THAN OCCUPATIONAL DISEASES)

Temporary disablement benefit

P.4.1. Temporary disablement benefit consists of periodical payments to an employee suffering from disablement as a result of an employment injury sustained as an employee under the Employees' State Insurance Act and certified to be eligible for such payments by an authority specified in this behalf.

Notice of accident

P.4.2. Every employee who sustains personal injury caused by accident arising out of and in the course of his employment in a factory or establishment covered under the Act is to give a notice of such injury either in writing or orally as soon as practicable after the happening of the accident, to the employer or such other person, e. g., foreman or other official authorised by the employer for the purpose. Such a notice can also be given by any other person acting on behalf of the employee. No such notice is required to be given by the employee if the employment injury is caused by an occupational disease(Reg.65).

Report of accident

P.4.3. On receipt of notice of employment injury, orally or in writing, from or on behalf of the employee or otherwise, the employer is required to enter immediately the particulars of the accident, as reported, in an accident book (form 15)* unless the entries are already made therein by the employee or some one else on his behalf. The employer will then investigate into the circumstances and the truth of the accident and send the accident report in form 16**, one copy to the appropriate Branch Office and another to the IMO/IMP to whom the injured person is attached. In case of a serious injury and particularly when it results in death at the place of employment, the report to the Branch Office and to the IMO/IMP must be sent through a special messenger, or otherwise, as speedily as may be practicable under the circumstances and in all other cases within 48 hours after coming to know of the accident(Reg.68 & 77).

P.4.4. In case the accident does not initially involve abstention from work on the day of accident, employer need not submit the accident report, but he must do so as soon as the same injury later results in abstention from work. However, entries must at once be made of all accidents in the accident book irrespective of whether the accident resulted in abstention from work or not. Separate register in form 15* may not be necessary if all the additional information required in form 15* is incorporated by the employer in a register maintained under the Factories Act.

P.4.5. The employer may send the accident report in the form prescribed under the Factories Act but after including all the additional particulars required in form 16**.

Contributory record

P.4.6. The employer shall also send the contributory record in form ESIC-32 alongwith the accident report in the following cases :-

- (a) Where the first benefit period has not commenced at the time of the accident.

*form 11 w.e.f. 1.1.05

**form 12 w.e.f. 1.1.05

- (b) Where, though the benefit period has commenced, the return of contributions for the relevant period is still with the employer at the time of the accident.
- (c) Any other case where the employer is so required for any special reason.

Further information on accident

P.4.7. The employer shall furnish to the Branch office or Regional Office such further information and particulars about an accident within such time as the said office may require.

First aid by employer

P.4.8. Every employer will arrange for such first aid and medical care and transport for obtaining such aid and care as the circumstances of the accident may require till the injured person is seen by the IMO/IMP.

Late submission of accident report

P.4.9. Proper investigation into a reported accident with a view to finding out the true facts is possible only if such investigation is made immediately after the accident. This is rather difficult where an accident is reported late by the employer. To ensure compliance on the part of employers in this respect, where the accident reports are submitted late repeatedly, the employer should be asked to give reasons for delay. On receipt of his reply which he must send within a reasonable period, the case should be examined with a view to determining whether the employer should be prosecuted for late submission of accident reports or not.

P.4.10. Where a prosecution is recommended, the Branch Manager should submit all relevant papers including the explanation of the employer, if available, and also diary numbers and dates of actual receipt of the reports from the employer during the last six months to the Regional Office alongwith his comments. It should be ensured that action is taken promptly in such cases so that prosecution is launched as early as possible from the date of default.

Action by the Branch Office on accident report

P.4.11. Every accident report will, immediately on its receipt in the Branch Office, be brought to the notice of the Manager. He will go through each report and put his dated initials thereon. He will then record instructions where investigation is necessary. The accident report will then be immediately diarised in the Branch Office Accident Report Register (ESIC-57). The serial number in the Accident Report Register will be marked on the accident report.

Cases to be investigated

P.4.12. The following accidents must be investigated:

- (a) All cases of occupational disease [see chapter IVA] ;
- (b) where the injury is likely to result in death or permanent disablement;
- (c) where the Manager has doubt about the facts contained in the accident report;
- (d) where the accident report is received in the Branch Office more than 20 days after the date of the accident;
- (e) an accident occurring outside factory premises involving an employee who is not normally on outdoor duty;
- (f) where there is material difference between accident report, B.I.1 and the first certificate;
- (g) accident occurring before submission of declaration form.

P.4.12A Hon'ble High Court of Gujarat, taking a serious view of some employers' tendency to avoid submission of declaration forms until after an accident occurs to a newly recruited employee, had

held that ESIC is not liable to pay employment injury benefits in respect of such an employee on his death resulting from an employment accident. Keeping in view this decision as well as ESIC's basic objectives to provide benefits to employee's and their families, it has been decided that the Regional Director may accept declaration form submitted by an employer in respect of an employee who has sustained employment injury resulting in his death/disablement, subject to the condition that the declaration form in respect of him/her had been duly signed by the deceased/ disabled one. However, claim for disablement/death benefit, as the case may be, should be admitted only after a thorough investigation about genuineness of such a case. If any claim is to be rejected, Regional Director should record the reasons for such rejection.

P.4.13. If the Branch Manager finds that investigation is necessary, he will record his order on the accident report and also indicate the name or designation of the official who will conduct the investigation.

P.4.14. In regard to cases likely to result in permanent disablement, it is clarified that likelihood of permanent disablement can only be judged from the description of nature, extent and location of the injury in the accident report, the medical certificate and/or the B.I.1, etc. There may be cases where such a description did not warrant investigation in view of the incomplete particulars available to the Branch Office. Once such cases are admitted, spot investigation need not be done even if such cases result in permanent disablement. It will, however, be checked that there were good reasons for each such case not being investigated initially.

Accident occurring at outstations

P.4.15 Normally, decision on employment injury in such cases may be taken by the concerned Branch Office on the basis of records /information/evidence available in the factory./estt. in which the IP is employed. However, where it is felt that spot investigations are necessary and unavoidable to establish a fact, the nearby Branch Office of the place where accident took place, even if it falls in the other region, may be requested directly by Branch Manager to do the needful. Copies of relevant papers, i.e., form 16**, ESIC 25, etc., etc., may be sent directly to that Branch Office. That Branch Office shall, on receipt of all such documents, investigate the required facts and record its findings in ESIC 25. This should be done on top priority to avoid delay.

Sickness benefit in lieu

P.4.16. In cases where the decision about employment injury is likely to be considerably delayed due to some complication, the Branch Manager, in order to minimise hardship to the insured person, may direct payment of sickness benefit (if due) to be adjusted towards temporary disablement benefit if that is eventually found due. There should, however, be no slackness in investigation and decision on such employment injury cases on account of interim payment of sickness benefit. Payment of sickness benefit in such cases should not be a routine.

P.4.17. A note about interim payment of sickness benefit may also be recorded in red ink in the TDB columns of the ledger sheet and the Accident Report Register so that, after decision on the case, the payment is invariably regularised by adjustment and no double payment is made.

Persons competent to investigate

P.4.18. All cases of occupational diseases whether fatal or non-fatal and cases of accident resulting in the death of the employee should be investigated personally by Branch Manager or the Dy. Manager, where there is one. Accident cases referred to in item (g) of para P.4.12 should also be personally investigated by BM or Deputy Manager immediately and if it comes to his notice that the employer has not been complying with the provisions of the Act in respect of all the coverable employees and resorting to submission of declaration forms only after an accident takes place, full facts should be reported to Regional office for initiating appropriated legal action against the defaulting employer. Branch Manager should also inform the employer in writing about non-submission of declaration form, with a copy to

**form 12 w.e.f. 1.1.05

Regional office. The investigating officer must report number of persons found coverable in the unit. Other cases may be investigated by the Manager or the Dy. Manager or any other official not below the rank of an upper division clerk.

P.4.19. In an area served by a Pay Office, the cashier may conduct investigation in all cases which are to be investigated on the spot. However, if it is a case of occupational disease or death, the Manager or Deputy Manager should himself investigate provided an early opportunity to visit that area occurs in the normal course or if the area is within a few kilometres of the Branch Office or if the case is otherwise doubtful.

P.4.20. Where, in an area served by a Pay Office, accidents resulting in death or occupational diseases are investigated by upper division clerk or higher official but not by the Manager or Dy. Manager, a random sample check should be made by the Manager whenever an opportunity occurs. Cases of death and occupational diseases in a Pay Office may be accepted on the recommendation of cashier or UDC, if the accident report, the investigating official's report, statement of witnesses and Insurance Medical Officer's report corroborate one another.

Action on the accident report

P.4.21. The accident report should be diarised on the date of receipt in the accident report register (ESIC-57) immediately after the Manager has recorded his instructions on the report. The serial number in the accident report register should be a continuous number for each financial year. In cases where the Manager is not available at the Branch Office at the time when the report is received, it should first be diarised and then put up to the Manager for his orders.

P.4.22. The date and time of the receipt of the report at the Branch Office should be indicated on the top right corner of the report.

P.4.23. The report where investigation is ordered, should be passed on immediately to the investigating official/Manager, as the case may be.

P.4.24. If the insured person happens to be attached to another Branch Office, the dealing clerk will send the report to that Branch Office for further action. Accident reports kept by the claims clerk in pending folder shall be linked by him with the first or subsequent certificate received for the same accident. The two documents so linked shall be left in the certificate folder till the insured person calls for payment. Further action to be taken is explained in Chapter-III-General Claims Procedure.

P.4.25. With a view to ensuring that all cases of employment injury entered in the accident report register are disposed of in time and to avoid any omission in pursuing them, the register must be reviewed by Manager periodically. While reviewing, he may initial against cases which have been disposed of. A monthly summary of accident reports received and disposed of shall be recorded in the register at the close of each month. The summary may contain the following information :-

- (1) Cases outstanding at the close of the previous month.
- (2) Number of accident reports received during the month.
- (3) Total number of cases pending at the close of the month.
- (4) Serial numbers of pending cases.

The Manager will check the monthly summary, particularly with reference to outstanding cases, find out the exact causes of delay and initiate prompt action for their final disposal.

Investigating official's visit to factory

P.4.26. Soon after the receipt of an accident report which is marked for investigation, the investigating official or the Manager, as the case may be, will go to the place of accident personally to make investigation on the spot and record his findings. The investigating official shall carry with him the accident report, blank form ESIC-25, and any other necessary documents (e. g., form ESIC-32 where submitted by the employer). A copy of ESIC-25 is at Annexure I.

P.4.27. The investigating official should first get the accident report completed by the employer in case it is incomplete in any material particular. He must also ensure that there is no over-writing or unattested correction in the accident report.

P.4.28. He should next examine the accident book maintained by the employer in order to see that the accident under report is properly recorded therein and that there is no material discrepancy between the accident reported and as recorded in the accident book. In case of any material discrepancy, he should ask the employer to clarify it, but he should at the same time make independent enquiries to test the truth of the employer's clarifications and to come to his own opinion on facts.

P.4.29. If the accident report does not name witnesses to the accident, these should be noted from Col. 17 of the accident book and then these witnesses should be asked to give statements. The investigating official should record this fact and names etc. of the witnesses in ESIC-25.

P.4.30. He should also check if any first-aid was provided by the employer. The date, time and nature of injury indicated in the accident report may be verified with the same particulars in the first-aid record, if any, maintained by the employer. An extract of the first-aid record may be taken, if available.

P.4.31. The investigating official should next examine the attendance register to verify that the injured person and the witnesses indicated in Form-16** were present on the day of accident. He should also check whether abstention from work has lasted 3 or more days excluding the day of accident. If the employee returned to work within this period, he is not entitled to temporary disablement benefit and no further investigation is necessary in the case.

P.4.32. The coverage aspect of the injured person as an 'employee' also be examined with reference to factory records, nature of his work, and his remuneration. This must be done particularly in case of doubtful or delayed coverage and persons who were not covered earlier.

P.4.33. In case of an accident which occurred outside the factory premises, or if the insured person was injured in course of work beyond the normal scope of his employment, the investigating official should check the 'job book' or 'order book' or some other relevant record of the employer to verify that the injured person was in fact deputed by the employer on that duty or deputed to work outside the premises on the date of the accident. The facts recorded on this point should be carefully examined in the light of instructions in the 'Law' part of this chapter before a decision is taken in the case.

Visit to spot of accident

P.4.34. The investigating official, after having examined the records, should visit the actual spot where the accident occurred and examine the particular part and the position of the machine etc. which caused the accident/or on which the injured employee was working when he sustained injury. He should, at the same time, note whether the employer has provided necessary safety guard for the machine which caused the accident. If required by the Regional Office in case of any particular factory or class of factories, this information can be supplied to the Chief Inspector of Factories.

**form 12 w.e.f. 1.1.05

P.4.35. If verbal description of the accident does not give a clear picture of the facts, the investigating official may prepare a rough sketch of the machine or part which caused the accident.

Examination of employer's record

P.4.36. The investigating official should next proceed to examine the witnesses mentioned in the accident book and, if necessary, other persons who were working at the time of the accident near the place of its occurrence and who have first-hand knowledge of it. Oral examination of witnesses is ordinarily sufficient. But where materially different versions are given by different witnesses or their versions conflict with the particulars in form 16** or in the accident book, or where the evidence is against the employee or is doubtful, it is desirable to obtain written statements.

In all such cases, it is necessary to contact the injured person himself to obtain his written statement, so that nothing is decided against him unless he is fully heard.

P.4.36A. Where the statement of an illiterate witness or other illiterate person is recorded by the investigating official himself, it should invariably be read out to him and then his declaration recorded at the end, "The statement has been duly read out to me and is correct". The signature or thumb impression should then be obtained on the statement.

P.4.37. If there are contradictions or variations in the statements, the investigating official should bring them to notice of the employer or witnesses, as the case may be, and obtain their clarifications which should also be duly recorded under their signature/thumb impression in the same way as the original statements.

P.4.38. In all cases enquiries from the employer or his representative should be made to find out whether he has ascertained the truth of the accident as reported to him before sending the accident report to the Branch Office and IMO/IMP.

P.4.39. Whenever an accident is investigated on the spot, the investigating official should also verify the rate of contribution with wage record as well as verify the number of days for which wages were paid in the contribution period relevant to the benefit period in which the accident occurred in all cases where this verification is prescribed under instructions. He may record such verification on ESIC-25.

Investigation of unreported accident

P.4.40. The procedure for investigating accidents not reported by the employer but otherwise brought to the notice of the Corporation will be the same as for reported accidents. The following additional points have, however, to be investigated:-

- (a) The investigating official must check whether the employer has reported the accident to the Chief Inspector of Factories and other agencies and if so the date on which such reports were sent. If possible, copies of such reports may be obtained duly attested by the employer.
- (b) The investigating official must ascertain the cause of employer's default in sending the accident report. He must see whether the employer's default was due to employee's failure to give notice.
- (c) He must attempt to find reliable evidence to corroborate the statement made by the employee in his representation or claim relating to the alleged accident. In particular, he must note whether he finds anything which is inconsistent with the employee's statement.

**form 12 w.e.f. 1.1.05

- (d) Statement of the eye-witnesses, the injured employee, the employer or his representative should be recorded in writing over their signature or thumb impression.

P.4.41. After the investigating official has completed his investigation, he should, if he finds that an accident did occur as alleged, obtain a report in form-16** from the employer even at this stage.

P.4.42. If the investigating official finds that no notice was given by the employee and that there was no sufficient and reasonable cause for such failure, he should make a note about the same in his report. If he finds that the employee's failure to give notice was due to sufficient and reasonable cause, he should record this fact in the remarks column of his report (form ESIC-25). In all cases where the injured person failed to give notice, the statements of the witnesses of the injured person and the employer or his agent should be taken in writing and enclosed with the report. The causes for the delay should be very clearly brought out in the statements. Accidents of this nature call for a deeper probe.

Daily rate of benefit

P.4.43. As per Rule 57 (3)(a) of the Central Rules, for an employee who sustains employment injury on a date which falls in his first or subsequent benefit period, the full rate of disablement benefit was the rate forty percent more than the standard benefit rate in respect of him, rounded to the next higher multiple of five paise. This daily rate has been revised upwards with effect from 1.12.2007 to fifty percent more than the standard benefit rate in respect of him, rounded to the next higher multiple of 5 paise.

P.4.44. As per Rule 57 (3)(b)(i), for an employee who sustains employment injury on a date which falls before the commencement of his first benefit period but after the expiry of his first wage period in the contribution period, the full disablement benefit rate is the rate fifty percent more than the standard benefit rate rounded to the next higher multiple of five paise corresponding to the wage group in which his average daily wages during that wage period fall.

P.4.45. . As per Rule 57 (3)(b)(ii), for an employee who sustains employment injury on a date which falls before the commencement of his first benefit period as well as before the expiry of his first wage period in the contribution period, the full disablement benefit rate will be the rate fifty percent more than the standard benefit rate rounded to the next higher multiple of five paise corresponding to the group in which wages were actually earned by the employee or which would have been earned had he worked for a full day on the date of accident, fall.

P.4.46. The standard benefit rate in respect of an employee whose case falls in para P.4.43 will be calculated in the same manner as for sickness benefit, the procedure for which is provided in Chapter III – General Claims Procedure.

P.4.47. The average daily wage in respect of an employee whose case falls in paragraph P.4.44 and P.4.45 will be calculated as under:-

- (a) In respect of an employee who is employed on time rate basis, the average daily wage will be calculated by dividing the amount of wages payable to him for the complete wage period had he worked for all the working days in that wage period divided by 26, 13, 6 or 1 according to he being a monthly, fortnightly, weekly or a daily rated person.
- (b) In respect of an employee employed on any other basis, the average daily wages will be worked out by dividing the wages earned during the complete wage period in the contribution period by the no. of days in full or in part for which he worked for wages in that wage period.

P.4.48. The following illustrations will make the position clear:-

Illustration I(See para P.4.43)

Ms. Anooradha

Date of entry:	1.6.06
Date of employment injury:	21.9.07
Relevant benefit period	1.7.07 to 31.12.07
Corresponding contribution period:	1.10.06 to 31.3.07
Wages paid during the said contribution period:	Rs. 5105.50
Days for which wages paid:	55
*Standard benefit rate:	Rs. 58.00
Daily rate of temporary disablement benefit:	Rs. 81.20

*For the purposes of calculation of temporary disablement benefit only because she is not entitled to sickness benefit

Note: If Anooradha had sustained employment injury due to accident occurring on or after 1.12.07, her TDB rate would be 50% more than the standard benefit rate, i.e., Rs.87/-p.d.

Illustration II (See para P 4.44)

Shri M. Swaminathan

Date of entry:	1.4.08
Date of employment injury	20.9.08
Rate of monthly wages (April, 08) during first wage period in the contribution period (April 08 to September 08):	Rs. 7550
Standard benefit rate:	Rs. 150.00
Daily temporary disablement benefit rate:	Rs. 225.00

Illustration III (See para P. 4.45)

Shri Prem Singh:

Date of entry:	1.4.09
Date of employment injury:	2.4.09
Monthly rate of wages:	Rs. 5200.00
Standard benefit rate:	Rs. 103.00
Daily temporary disablement benefit rate:	Rs. 154.50

P.4.49. If in the contribution period corresponding to the benefit period in which the accident occurs, the injured person being an old entrant had not paid any contribution, i. e., having gone out of coverage as an 'employee' under the Act due to a raise in wages or was not in insurable employment, he should be treated as a new entrant for the purpose of determining rate of temporary disablement benefit in terms of para P.4.44 or P.4.45 above, as the case may be.

Verification of wages etc.

P.4.50. Verification of wages as well as counting of days for which wages paid will be done in cent percent cases of death due to employment injury. Such a verification in cases likely to result in permanent disablement will be limited to only those cases where the rate of temporary disablement is calculated on the basis of ESIC-32/ESIC-71 and not on the basis of return of contributions. No verification is necessary if rate of temporary disablement benefit is calculated on the basis of return of contributions. If rate was calculated earlier on the basis of ESIC-32/ESIC-71 in a case which later resulted in permanent disablement benefit, verification of wages as well as counting of days for which wages paid, should be done subsequently. The result of wage verification should be recorded by the inspecting official by means of a certificate on ESIC-32/ESIC-71 as under:-

“Both number of days paid and amount of wages paid checked from the employer’s record and found correct”.

P.4.51. Where the rate is decided on the basis of ESIC-32/ESIC-71 received from the employer and not from the return of contributions already lying with the Branch Office, the standard benefit rate calculated on the basis of ESIC-32/ESIC-71 should be verified with the return of contributions lying with the employer if the accident is otherwise to be investigated. All other cases of ESIC-32/ESIC-71 should be eventually tallied with the corresponding entries in the return of contributions when these are ultimately received in the Branch Office. The folder containing paid accident reports and ESIC-32/ESIC-71 should be reviewed to ensure and record that this check is carried out when the return of contributions is received in the Branch Office.

P.4.52. Subject to the foregoing para,

- (i) where accident occurs before commencement of the first benefit period, the particulars furnished by the employer in ESIC-32 shall be personally verified by the BM with the wage record and a verification certificate recorded by him on the ESIC-32. The audit will verify the rate on the basis of the certificate recorded by the BM on ESIC-32.
- (ii) Similarly, a certificate recorded by the investigating official and duly countersigned by the Branch Manager on the ESIC-32/71 after verification of employer’s record in cases of accidents when relevant return of contributions is not available in the Branch Office, will be relied upon for all the purposes of calculation and verification of rate of disablement benefit.

- (iii) Where the factory/establishment has closed down or where the relevant wage records are not available with the employer, the rate of disablement benefit should be determined by the Regional Office in consultation with the Dy. Director (Finance) on the basis of the previous records or return of contribution for the previous period pertaining to that IP.

P.4.53. Where the rate is decided on the basis of ESIC-32/ESIC-71 from the employer and not from the return of contributions already lying in the Branch Office, the standard benefit rate calculated on the basis of ESIC-32/ESIC-71 should also be compared with the standard benefit rate last recorded on the ledger sheet and if the rate on the basis of ESIC-32/ESIC-71 is higher by two or more denominations, the temporary disablement benefit rate should not be authorised until the particulars of wages and days for which wages paid as recorded in ESIC-32/ESIC-71 have been verified with the records of the employer.

P.4.54. If the employer is a defaulter, particulars of wages paid and the days for which wages paid should be verified from his record before authorising payment of temporary disablement benefit and permanent disablement benefit. This equally applies to cases where an insured person meets with an accident before the start of his first benefit period and / or before completion of the first wage period. (Invariably in every case of death due to employment injury, verification of wage record and of the records of days for which wages paid/payable is compulsory).

P.4.55. In all cases involving payment of permanent disablement benefit, dependants' benefit or commuted value, the employer's record should also be checked to verify that contributions due for the wage period (including the date of accident) in which accident occurred have been paid so that there is no loss of revenue. This verification will, however, not be a pre-condition to the payment of benefit.

P.4.56. Contributory record furnished by the employer in Form ESIC-32/ESIC-71 where employees' contribution has been paid on *ad hoc* basis should invariably be verified with the wage records maintained by the employer. If such verification is not possible, the matter may be referred to Headquarters for approval.

P.4.57. In all cases where payment of temporary disablement benefit was authorised on the basis of contributory particulars furnished by employer in ESIC-32/ESIC-71 and not on the basis of the return of contributions with the Branch Office, an entry should be made in ESIC-71 register to watch for the receipt of return of contributions for the relevant contribution period, and to report to Regional Office for action for recovery of contributions in case the same is not received. For details of action to be taken in such cases please refer to Chapter VII-Sickness Benefit Procedure.

Payment at incorrect rate

P.4.58. In cases where the contributory record on ESIC-32/ESIC-71 or the return of contributions is checked with wage record after temporary disablement benefit has already been paid, and it is found that due to the incorrect rate shown by the employer, there has been erroneous overpayment of benefit, the following action should be taken:

- (a) If payment at the incorrect rate is continuing, the rate should immediately be corrected for future payments and the amount paid in excess be recovered.
- (b) If it is found that overpayment was made due to employer's error in form ESIC-32/ESIC-71, an attempt should be made to recover the amount from the employer.
- (c) Where there is some evidence to show that the employer had given false information in form ESIC-32/ESIC-71 or the return of contributions knowingly with intention to secure higher benefit for the insured person, prosecution action u/s 84 of the Act should be recommended and the Regional Director should take further necessary action in this connection.

Underpayment of benefit

P.4.59A. If, on checking form ESIC-32/ESIC-71 or the return of contributions, it is found that there was underpayment of benefit, the case should be re-opened –

- (a) if the claimant himself points out the error; or
- (b) if the error affects future payments; or
- (c) if the amount involved is in excess of Rs. 10/-

P.4.59B. (1) The authority to re-open cases under para (a) to (c) above vests with the Manager. Only the number of such cases where the case was re-opened on the initiative of the insured person or otherwise and indicating the total amounts involved in respect of each Branch Office should be incorporated in the monthly progress report.

- (2) An entry should be made by the Branch Office in the register of underpayments (as per proforma of the register of underpayments given below) and the amount involved paid to the claimant.
- (3) In cases where the amount involved is Rs. 10/- or less and the underpayment has neither been pointed out by the claimant nor does it affect future payments, no entry should be made in the register of underpayments and as such these cases are not to be re-opened.

Proforma for register of underpayments to be maintained at Branch Office

Sl. No	Name of I. P. & Ins. No.	Period of underpayment	Nature of benefit payment	Causes of underpayment
1	2	3	4	5

Total amount of underpayment and its rate	Date of payment of amount as in col. 6	Re-opened at the instance of			Remarks
		I. P.	B. O.	External audit/local audit	
6	7	8	9	10	11

Checking of TDB rate

P.4.60. Rate of temporary disablement benefit as calculated should be invariably checked by checker. Manager should re-check 10% of rates calculated on ESIC-32/ESIC-71/return of contributions.

Preparation of employment injury report

P.4.61. As soon as the investigation of the accident has been completed, the investigating official will prepare a report of the accident on form ESIC-25 (Annexure I). The following points should be borne in mind when completing the form:–

The report should be prepared in duplicate.

- (i) Where the insurance number of the insured person is not known, the serial number of the declaration form on the return of declaration forms, alongwith the instalment number, and the date of submission of declaration forms by the employer should be indicated so that the relevant papers can be connected at the Branch Office/Regional Office.
- (ii) Columns 12 to 15 are to be repeated from the employer's accident report in form 16 (form 12 w.e.f. 1.1.05).
- (iii) Against column No. 23 investigating official should write down the names of all persons contacted. These may include persons other than those mentioned in column 15 of ESIC-25.
- (iv) Where the accident report is submitted late, while noting particulars in column 24 of the report the investigating official must also record in case the accident occurred in a factory if the report of the accident was sent timely to the Chief Inspector of Factories or other authority. (In that case, copies of such reports sent duly attested by the employer may also be enclosed with the report).
- (v) While recording information against column 26, an extract from the first aid register in respect of the accident if maintained, may also be recorded on the report.
- (vi) Against columns 18 to 23 under the heading "Findings of the official" every answer must be definite and to the point. In most cases it should be 'yes' or 'no'. But where the investigating official wants to give details (e. g., where his findings are different from those reported by the employer in the accident report) he can attach a separate sheet with ESIC-25 if he finds the space on the form insufficient.
- (vii) Where he finds any contradictions in or between the statements of witnesses, the injured employee, the employer or his agent, he must try to reconcile the difference after interrogation of the witnesses and also obtain their written statements clarifying the position.
- (viii) The investigating official should send his report with his opinion whether the case is one of employment injury or not.

Accident occurring outside factory

P.4.62. In case of accidents occurring outside the premises of factory/establishment, the following further information may be ascertained by the investigating official:

- (a) Is a job card for the injured employee maintained in the factory/establishment? If so, does it show that he was deputed for work outside the factory?
- (b) If no job card is maintained, does the nature of work of the employee require him to go outside the factory? Was he sent out by the employer?
- (c) In case no record is available indicating the movement of the injured employee to the place of accident, a written clarification from the employer may be obtained.
- (d) Was the injured employee deputed to work outside the factory/establishment alone or alongwith some other employee? In the latter case, the statement of such co-workers regarding the details of accident should also be obtained.

- (e) In case the accident was not witnessed by a co-employee, statement of any other eyewitness to the accident may be obtained through the injured employee, if he can cite such a witness.

Comparison of ESIC-25 with B.I. 1 or First Certificate

P.4.63. The IMO/IMP who received a copy of the accident report from the employer and who first examines the injured person, will send his own report on form B.I.1 to the Branch Office. On its receipt, the concerned clerk will make an entry on the same line in the accident report register where the accident report was entered. He will then stamp it with the Branch Office stamp and write on it the date of its receipt and its serial number in the accident report register. The clerk will then pass on form B.I.1 to the investigating official (if the case is to be investigated) or to the clerk who has to deal later with the claim.

P.4.64. The official receiving B.I.1 will scrutinise it and compare it with report on ESIC-25 (if the accident has been investigated) and with the accident report on form 12. He must particularly compare the location, extent and nature of the injury recorded in the different reports. He will next initial B.I.1 and attach it with the accident report. If he discovers any material discrepancy he should, with the approval of the Manager, make necessary enquiries from IMO/IMP, the insured person or the employer, as the case may be, so as to clarify the discrepancy. Such clarifications may be obtained, as far as possible, in writing and placed before the Manager. If they are satisfactory, further action may be taken towards admittance of the case. In case the discrepancy is not reconciled, the case should be referred to Regional Office.

P.4.65. If the IMO/IMP's report on form B.I.1 has not been received by the time the investigating official completes the report or the insured person makes his claim, the investigating official (if the case was investigated), or the claims clerk will check the first certificate received in the Branch Office. He will then compare the nature, extent and location of the injury on the certificate with the same particulars on the accident report and on form ESIC-25 (if the accident was investigated). Such a comparison should be made even if the first certificate or form B.I.1 is received after the receipt of the accident report and form ESIC-25. In case of any discrepancy, steps to reconcile it should be taken and case referred to Regional Office for decision where reconciliation is not possible inspite of efforts. Disposal of the claim should, however, not be kept pending merely for want of B.I.1.

Authorities to decide employment injury

P.4.66. The Manager (except when he investigates on behalf of another Branch Office) will himself give final decision on all employment injury cases except the following which should be referred to the Regional Office for decision:

- (i) All cases of occupational diseases.
- (ii) Where the injured person has died as a result of the accident except inside the factory premises or shop floor, *vide* para P.6.5A of Dependants' Benefit Procedure.
- (iii) Where the Manager/investigating official, after scrutinising form 16, ESIC-25 and form B.I.1 or the first certificate, feels that the injury is likely to result in permanent disablement, partial or total. However, *vide* Hqrs. Memo No., R-13/12/Policy/97- Ins.I, dated 17.2.2000, such cases may be admitted, after due investigation, by the Branch Manager for payment of temporary disablement benefit.
- (iv) All cases of accident occurring outside the factory premises except those where the injured employee's nature of work involves outdoor duties as a routine.
- (v) Where the three reports, viz., the accident report, the investigating official's report and the IMO/IMP's report on Form B.I.1 (or first certificate) give materially different versions of the nature, extent or location of the injury or the circumstances in which it

was sustained and the Manager, after instituting enquiries into the discrepancies, has not been able to get them reconciled.

- (vi) Where the documents in sub-para (iv) above agree with one another but the nature and the circumstances of the injury indicate that it is not an employment injury.
- (vii) Cases in which the Manager himself thinks it desirable to make a reference to the Regional Office.

P.4.67. The investigation report on form ESIC-25 together with the accident report, form B.I.1 and first certificate, if received by then, will be placed before the Manager and he should consider the whole case and if he feels any further investigation is necessary, he may himself conduct the same or ask investigating official to do so on lines to be indicated by the Manager. In case he is satisfied about the result of investigation, he should record on ESIC-25 as follows over his full signatures with date:

“On the basis of enquiries conducted in the case or the facts disclosed I am satisfied that it is a case of employment injury”.

Where an accident is admitted without investigation, the Manager will record “Admitted” with his full dated signatures on the accident report.

P.4.68. Where the case is to be sent to the Regional Office for decision (the IP being attached to investigating Branch Office), the receipt clerk will despatch to the Regional Office all the documents of the accident, including accident report, original copy of ESIC-25, B.I.1 or relevant extracts from the first certificate. When the papers are forwarded to Regional Office, necessary entries should be made in the accident report register (ESIC-57). Second copy of ESIC-25 should be retained in the folder of pending accident reports. Branch Office accident report register should be reviewed periodically and Regional Office should be reminded in case decision is not received on any report submitted to it.

P.4.69. Where the insured person is attached to some Branch Office other than the investigating office, the receipt clerk will despatch both copies of ESIC-25 and other papers, including statement etc., in original to the other Branch Office and make out and retain a triplicate copy of ESIC-25. He will then complete the appropriate columns of the Branch Office accident report register for record.

P.4.70. In cases referred to in previous para, when papers are received at the Branch Office to which the employee is attached, the receipt clerk will enter them in his accident report register and thereafter put up the papers alongwith B.I.1 or first certificate, ESIC-25 etc., to the Manager who will record his decision on the accident report after taking into account the recommendations of the Manager who forwarded the case. Cases needing reference to Regional Office will be forwarded to that office with the necessary papers.

P.4.71. After payment of temporary disablement benefit, the connected papers shall be stamped “cancelled” and filed in a separate folder in the order of the dates of payment with cross reference to the accident report register.

Receipt of case from Regional Office

P.4.72. When decision about the accident is received at the Branch Office from Regional Office, entries will be made in Branch Office accident report register and further action taken thereon as if the decision was of the Manager.

Return of pending accident reports

P.4.72A. Return of pending accident reports for a month or more should be submitted to Regional office by the 10th of the next month in form MISLO-04 (item 3).

Delay in reporting for treatment, etc.

P.4.73. Temporary disablement benefit is not payable for an employment injury unless an employee's temporary disablement is duly certified for not less than 3 clear days excluding the day of accident as a result of the employment injury. These three days may not begin immediately after the accident nor need they be continuous though cases of this kind should be very rare. If the gap between the date of injury and the date of issue of first certificate issued for it, both days exclusive, exceeds 7 days, the Branch Manager may accept the claim for temporary disablement benefit only after the Medical Referee has confirmed the connection between the employment injury and the incapacity certified on the first certificate.

Payment for day of accident

P.4.74. Temporary disablement benefit is payable for the day of accident only if the employee produces a medical certificate for that day and it is established that no wages are payable for that day. If an employee claims benefit for the day of the accident, he must produce a confirmation in writing from the employer about non-payment of wages for that day or the Branch Office may make a specific enquiry to this effect from the employer.

P.4.75. For counting the days for eligibility to TDB, the days (excluding the date of accident), on which the employee was actually certified as incapable of work should be taken into account, even if incapacity was caused or aggravated by failure on his part to take necessary treatment. Further, benefit cannot be suspended in such cases unless the employee fails to observe the instructions of the IMO/IMP after he has reported to him.

Relapse of temporary disablement

P.4.76. If the subsequent spell of incapacity after recovery commences within 7 days, temporary disablement benefit for the subsequent spell can be paid by the Branch Office itself on the recommendation of the IMO/IMP confirming that it is a relapse of the earlier spell.

P.4.77(i) If the subsequent spell after recovery commences after 7 days but within 14 days, temporary disablement benefit for the subsequent spell can be paid by the Branch Office itself on the recommendation of the Medical Referee.

(ii) If the subsequent spell commences after 14 days the case should be decided at the Regional Office on the recommendation of the Medical Referee if one is posted at Regional Office.

Long spells of temporary disablement

P.4.78A. In order to have a check over the payment of temporary disablement benefit and to limit the duration of period for which temporary disablement benefit is payable, Branch Manager should refer such a category of TDB cases to the Medical Referee at least every fortnight through incapacity references except in case of fractures etc., which necessarily involve a long period of incapacity.

P.4.78B. In every case where temporary disablement has continued for a period of more than six months, the Medical Referee may recommend reference to the Medical Board for assessment of permanent loss of earning capacity unless he is satisfied that there is no justification for making such a reference at this stage. Where reference to Medical Board is not recommended, Branch Office should exercise proper check by reviewing every case periodically so that in no case the incapacity is prolonged unduly. But reference of such cases to Medical Board should be avoided till temporary disablement is terminated.

P.4.78C. New standard benefit rates introduced from 19.9.98 have made SB rates at least 57.5% of wage rates. TDB Rates are 50% over and above these rates. An IP in receipt of TDB thus receives at least 86.25 % of his wages. There is also no limit on the duration of TDB. Although TDB as well as its duration represent the Corporation's anxiety to help the IPs in meeting their reasonable needs during the

period of their incapacity due to industrial accidents, yet both offer a temptation for prolonging the period of abstention. Thus the increase in the daily rates of benefit should make the Branch Manager more vigilant beyond what is absolutely necessary. The instructions provided in the preceding para have, therefore, to be scrupulously followed apart from whatever other steps Branch Manager may consider necessary to prevent malingering in temporary disablement.

High incidence of accidents in a factory

P.4.79. Speaking of individual factories (particularly the large ones) tendency to prolong incapacity resulting from employment injury, may be noticeably present amongst the casual and substitute workers even for injuries that are minor or, at times, even non-existent. Such a tendency may rise abruptly when a factory gets closed down or when there is a spate of holidays during which casual and substitute workers would not get work, or at places having power-shedding. In order to exercise a check and to minimise the high incidence of temporary disablement benefit, Branch Managers are required to adopt the following remedial measures, among others, after necessary investigation in the factory:

- (i) Whenever the incidence of accidents in a factory appears excessive, i. e., higher than the all-India average by 25% or more, a record of accidents reported by it may be kept in a “register of accident frequency” in the following proforma:-

Name of factory Code No
 Nature of Industry No. of employees

Monthwise serial no.	Ins. Numbers in respect of which accident is reported	Frequency for the month
January 200.....		
1.		
2.		
3.		
4.		
February 200.....		
1.		
2.		
3.		
4.		

and so on.

The frequency of accidents per thousand employees per annum can be determined by multiplying the number of accident reports with 12000 and dividing it by the number of employees in the factory. Fractions below 0.5 should be ignored and fractions of 0.5 and above taken as 1 every month. The Manager should send to the Regional Director the names and addresses of the factories in whose case the frequency is excessive as described hereinabove. The Regional Director should bring the matter to the notice of the concerned employer(s) with a request to bring it down. A copy of the letter should be sent to the employers’ association to seek their assistance. If the measure does not help, the Chief Inspector of factories may be informed.

- (ii) In respect of non-existent injuries for which accident reports are submitted by the employer, Branch Manager/Regional Director will find it useful to invite attention of all

concerned to the provisions of Section 84, as now amended, wherein the punishment for false statement which helped the IP in obtaining benefit fraudulently (e. g. temporary disablement benefit in this case), has been enhanced to six months' imprisonment or fine upto Rs. 2,000/-, or both. The IP availing of TDB on the basis of a false report in respect of a non-existent injury, can also be prosecuted and awarded penalty as aforesaid. *Vide* Central Rule 62, an IP convicted for reasons aforesaid can, in addition, be barred from receiving cash benefit for a period of three months in case of first conviction and six months in case of subsequent conviction.

- (iii) The employers, particularly those responsible for disproportionately large number of accident reports, should be requested to enquire into each accident and to send an accident report only when satisfied by thorough enquiries that an accident had, in fact, occurred.
- (iv) It should be insisted that every accident report should be signed by a senior officer of the factory.
- (v) A process of education of the workers should start and the Labour Officers and other officers in the factory should approach the supervisors, chargemen, foremen, etc. and, through them, restraint should be exercised at the factory level on fake reporting of accidents or self-infliction or aggravation of injuries.
- (vi) Articles should be published and for this purpose figures of disproportionate payments should be reported to the Regional Director for publicity in the form of radio talks/telecasts and distribution of leaflets at the Branch Office, ESI dispensaries, IMP's clinics, factory/estt. etc., requesting the workers to co-operate with the Scheme.
- (vii) Contacts should be established by the Branch Manager with the mill union committees, particularly in big factories, as these committees can be helpful in influencing the workers.
- (viii) The percentage of spot investigation of accidents in factories where there is an appreciable rise in the incidence of accidents, may also be increased suitably to ensure proper check specially of accidents reported immediately before the period of closure, festival holidays, etc. At the time of investigation, it should also be verified if the employer has been reporting these accidents to the Inspector of Factories as required under the Factories Act. If these accidents have not been reported, the matter should be at once brought to the notice of Inspector of Factories who may also be requested to go into the safety measures provided by the employer with a view to checking if the high incidence of accidents is due to employer's failure to provide safety guards. In any case, such a step will have a salutary effect of curbing the incidence of accidents in the factory in question.
- (ix) The incidence of minor accident cases should be watched closely and the aspects like provision of safety measures and necessary training to the workers should be adequately emphasised on the employers.
- (x) Wherever necessary, co-operation of the Insurance Medical Officers through the State Medical Commissioner/Medical Referee and the Administrative Medical Officer may be sought to ensure that medical certificates for disability due to accident cover the minimum required period. If required, teams be got constituted by the Director, Health Services of the state to examine the IPs of such high incidence prone areas before issuing/recommending extension of leave on intermediate certificate.
- (xi) Labour organisations may also be taken into confidence and their co-operation sought where necessary.
- (xii) The areas or factories where the incidence of accidents/disablement benefit is excessive should be kept constantly under review from month to month.

- (xiii) The Local Committee should be activated and its meetings called more frequently with a view to formulating measures to weed out unscrupulous incidence of accidents/demands for certification. The members of the Local Committee, particularly the workers' representatives could use their personal influence to educate the insured persons.
- (xiv) A larger number of incapacity references should be initiated on priority basis covering suspected cases of malingering. Medical Referee be requested for examination of such cases if necessary at the Branch Office itself and with least possible delay.
- (xv) If all the above stated measures fail to bring the incidence of temporary disablement within the All-India average, recommendation should be made to the Regional Director with full justification, with a suggestion to take up the matter with Hqrs. Office for invoking the provisions of Section 91B of the Act which says as under:

“91B. Misuse of benefits – If the Central Government is satisfied that the benefits under this Act are being misused by insured persons in a factory or establishment, that Government may, by order published in the Official Gazette, disentitle such persons from such of the benefits as it thinks fit:

Provided that no such order shall be passed unless a reasonable opportunity of being heard is given to the concerned factory or establishment, insured persons and the trade unions registered under the Trade Unions Act, 1926 (16 of 1926) having members in the factory or establishment.”

FINDINGS OF THE OFFICIAL

18. Are the Particulars in 12,13 and 14 above as reported by the employer fully corroborated by the evidence? If not, statement of facts as found by the official.

19. Is there any evidence showing that the injury is not an employment injury?

20. Whether the employee at the time of accident was –

- (i) acting in contravention of the provisions of any law applicable to him or
- (ii) acting in contravention of any order given by or on behalf of his employer or
- (iii) acting without instructions from his employer or
- (iv) If reply to (i) to (iii) above is in affirmative, was the act done for the purposes of and in connection with the employer's trade or business?

21. In case the accident happened while travelling in employer's transport :

- (i) Whether the vehicle was being operated by or on behalf of the employer or some other person in pursuance of agreement with the employer.
- (ii) Was the vehicle being operated in the ordinary course of public transport service?

22. In case the accident happened while meeting emergency, did the accident happen while the employee was taking steps to rescue, succour or protect persons who were or thought to be or possibly to be injured or imperilled or to avert or minimise serious damage to property?

23. Persons interviewed

Sl. No.	Name	Deptt.	Shift	Residential Address	Whether accident confirmed

24. Was the injury reported to the Employer in time?
25. Has the entry been made in chronological order in the accident book ? If not, reasons therefor.
26. Was any first aid rendered by the employer and written record kept? If not, reasons therefor.
27. Has the injured person been marked present in the attendance register on the day of accident? If not reasons therefor.
28. Whether contribution for the day of accident has been paid/payable. If not, reasons therefor.
29. Did the injured person continue to work till the end of his shift?

Note: Additional remarks, if any, may be given below or on a separate sheet attached to this statement over the signature of the investigating official.

Signature of the investigating Official

**CHAPTER IVA
TEMPORARY DISABLEMENT LAW
(OCCUPATIONAL DISEASES)**

CONTENTS

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CHAPTER IVA

TEMPORARY DISABLEMENT BENEFIT LAW (OCCUPATIONAL DISEASES)

Definition of occupational disease (OD)

L.4A.1 Section 2(8) of the Act defines the term “Employment Injury”. This definition has been reproduced *verbatim* in para L.4.1 of the previous Chapter. In terms of occupational diseases, it would read as under: -

“Employment injury’ means a personal injury to an employee caused by an occupational disease arising out of and in the course of employment, being an insurable employment, whether the occupational disease is contracted within or outside the territorial limits of India.”

The term ‘occupational disease’ has not been defined but a perusal of sub-section (1) of Section 52A read with The Third Schedule of the Act makes it clear that it is a disease contracted by, or caused to, a person employed in one of the occupations described in the said Third Schedule.

Law on the subject

L.4A.2 Section 52A of the Act which is the relevant law on occupational diseases is reproduced as under :-

“52A(1) If an employee employed in any employment specified in Part A of the Third Schedule contracts any disease specified therein as an occupational disease peculiar to that employment, or if an employee employed in the employment specified in Part B of that Schedule for a continuous period of not less than six months contracts any disease specified therein as an occupational disease peculiar to that employment or if an employee employed in any employment specified in Part C of that Schedule for such continuous period as the Corporation may specify in respect of each such employment, contracts any disease specified therein as an occupational disease peculiar to that employment, the contracting of the disease shall, unless the contrary is proved, be deemed to be an “employment injury” arising out of and in the course of employment.

(2) (i) Where the Central Government or a State Government, as the case may be, adds any description of employment to the employments specified in Schedule III to the Workmen’s compensation Act, 1923 (8 of 1923) by virtue of the powers vested in it under sub-section (3) of Section 3 of the said Act, the said description of employment and the occupational disease specified under that sub-section as peculiar to that description of employment shall be deemed to form part of the Third Schedule.

(ii) Without prejudice to the provisions of clause (i), the Corporation after giving, by notification in the Official Gazette, not less than three months’ notice of its intention so to do, may, by a like notification, add any description of employment to the employments specified in the Third Schedule and shall specify in the case of employments so added the diseases which shall be deemed for the purposes of this section to be occupational diseases peculiar to those employments respectively and thereupon the provisions of this Act shall apply, as if such diseases had been declared by this Act to be occupational diseases peculiar to those employments.

(3) Save as provided by sub-sections (1) and (2), no benefit shall be payable to an employee in respect of any disease unless the disease is directly attributable to a specific injury by accident arising out of and in the course of his employment.

L.4A.2 The provisions of Section 51A shall not apply to the cases to which this section applies.”

L.4A.3 A copy of the Third Schedule of the Act may be seen at Annexure I. This Schedule has replaced the old schedule with effect from 27.1.1985 and is much more comprehensive than the earlier schedule.

L.4A.4 If an employee employed in any employment mentioned in Part A of the above- referred Schedule contracts any disease specified therein as an occupational disease peculiar to that employment, the contracting of the disease shall be deemed to be an employment injury arising out of and in the course of employment unless the contrary is proved. It would, thus, be observed that in so far as the diseases falling in Part A are concerned, the mere fact of being employed in the employment specified therein raises a presumption as to the contracting of the disease being an employment injury. No minimum period of employment is required.

L.4A.5 In so far as the occupational diseases specified in Part B of the Third Schedule are concerned, an employee employed in any of the employments specified therein for a continuous period of not less than six months becomes entitled to the presumption of the occupational disease amounting to an employment injury. All that is to be seen in this case is whether the employee had been, before the date of contracting the disease, in the specified employment for a continuous period of not less than six months. So long as the period of service is continuous, it does not matter whether the employee has served with the same employer or with different employers in the same kind of employment. But, each such employer should be of a factory or establishment covered under the ESI Act.

L.4A.6 As per sub-section (1) of Section 52-A, to claim compensation for diseases listed in Part C of the Third Schedule, a continuous period of employment such as the Corporation may specify in respect of each employment causing the disease related thereto is necessary. The Corporation had notified the following periods of continuous employment for the diseases included in Part C of the earlier Schedule as well as for certain other diseases added by it through a notification by virtue of powers vested in it under Sub-Section (2) (ii) of Section *ibid* :

Silicosis	6 months
Coal Miner's Pneumoconiosis	7 years
Asbestosis	3 years
Bagassosis	3 years
Byssinosis	3 years
Farmer's lung	5 years
Pneumoconiosis	7 years

L.4A.7 In respect of those diseases which find a place in the new Schedule, the relevant periods of employment remain unchanged while in respect of others now added, the periods of employment will be specified by the Corporation in due course and all concerned will be informed. In the meantime, deserving cases where minimum period of continuous employment is less than the period prescribed in one or more establishments, can be helped in the light of Corporation's Resolution dated 25/2/1992 given in Para L.4A.9 below.

L.4A.8 In all the cases mentioned in the preceding paras the presumption avails in favour of the claimant if he satisfies the conditions specified. If the Corporation contests the claim, the burden of disproving the occupational origin of the disease rests on the Corporation.

Relaxation of service condition

L.4A.9 The periods specified above for occupational diseases included in Part C caused hardship to those sufferers who could not fulfil the minimum qualifying period of employment. The Corporation, at its meeting held on 25-2-1992, resolved to add the following proviso to its Resolution passed earlier fixing the periods of employment for diseases under Part C :

“Provided that if it is proved that an employee whilst in the service of one or more employers in any employment specified in Part C of the Third Schedule to the ESI Act, 1948, has contracted a disease specified therein as an occupational disease peculiar to that employment during a continuous period which is less than the period specified by the Corporation for that employment, and that the disease has arisen out of and in the course of employment, the contracting of such disease shall be deemed to be an ‘employment injury’ within the meaning of Section 52A of the ESI Act, 1948.”

L.4A.10 The term ‘service of one or more employers’ should be deemed to mean that the previous employer(s) as well as the present employer should be of factory/establishment covered under the ESI Act. Further, the employment should have been continuous leading to the contracting of the disease.

Automatic additions to The Third Schedule

L.4A.11 The Third Schedule of the ESI Act, 1948 is exactly identical to Schedule-III to the Workmen’s Compensation Act, 1923 - a legislation under which compensation is payable to a workman sustaining a personal injury from accident or by contracting an occupational disease while in the employment of a factory or estt. not covered under the ESI Act, 1948. Section 3 of the WC Act empowers the Central Government as well as a State Government to add any description of employment as well as an occupational disease peculiar to such employment, to Schedule III to the WC Act. Sub-section (2) (i) of Section 52A of the ESI Act says that when such an addition is made by the Central or State Government, it shall also stand automatically added so as to form part of the Third Schedule to the ESI Act. In addition, the ESI Corporation has also been empowered by Section 52A(2) (ii) to add of its own accord any description of employment and the corresponding occupational disease in the Third Schedule to the ESI Act.

Occupational disease is not injury caused by accident

L.4A.12 The contracting of a disease is not as a rule an injury by accident; for one thing, it is usually not sudden (except perhaps a disease included in Part A of the Third Schedule). But here it is expressly provided that where the conditions mentioned in the preceding paragraphs are satisfied, the contracting of the disease is employment injury. Further, *vide* sub-section (1) of Section 52A, unless the contrary is proved, the contracting of the specific disease will be deemed to have arisen out of and in the course of employment, so that the workman’s case is complete without any further proof. It will very seldom be possible to prove that the occupational disease did not arise out of or in the course of employment. [A similar presumption is also available in the case of an accident *vide* section 51A of the Act.] But, if it is proved that the workman contracted the disease before he entered the insurable employment, the Corporation is not liable, even though service under the present employer may have aggravated it.

Compensation for disease other than occupational disease

L.4A.13 In so far as any disease other than the diseases specified in the Third Schedule is concerned, no disablement benefit is payable to an employee unless the disease is directly attributable to a specific injury by accident arising out of and in the course of employment. It would, therefore, be necessary in case of such other disease to prove that the disease constitutes an accident within the meaning of the word [and not within the special meaning of Section 52A(1)], that the accident arose both out of and in the course of employment and that the disease was directly attributable to a specific injury sustained in that accident.

Other Provisions

L.4A.14 The provisions regarding the following matters may be seen in relevant paras of Chapter IV – Law (Other Than Occupational Diseases), these being also applicable to occupational diseases:-

(i)	Definition of temporary disablement	L.4.65.
(ii)	Duration of temporary disablement benefit.	L.4.66 to L.4.67
(iii)	Conditions attached to grant of TDB	L.4.68
(iv)	Daily rate of TDB	L.4.69
(v)	Persons not entitled for TDB in certain cases	L.4.70
(vi)	Benefits not to be combined	L.4.71
(vii)	Recipients of SB/TDB to observe conditions	L.4.72 to L.4.73

THIRD SCHEDULE TO THE ESI Act, 1948

[Section 52 A]

List of Occupational Diseases

<i>Sl. No.</i>	<i>Occupational disease</i>	<i>Employment</i>
1	2	3

PART A

- | | | |
|----|--|---|
| 1. | Infectious and parasitic diseases contracted in an occupation where there is a particular risk of contamination. | (a) All work involving exposure to health or laboratory work;
(b) All work involving exposure to veterinary work;
(c) Work relating to handling animals, animal carcasses, part of such carcasses, or merchandise which may have been contaminated by animals or animal carcasses;
(d) Other work carrying a particular risk of contamination. |
| 2. | Diseases caused by work in compressed air. | All work involving exposure to the risk concerned. |
| 3. | Diseases caused by lead or its toxic compounds. | All work involving exposure to the risk concerned. |
| 4. | Poisoning by nitrous fumes. | All work involving exposure to the risk concerned. |
| 5. | Poisoning by organophosphorus compounds. | All work involving exposure to the risk concerned. |

PART B

- | | | |
|----|---|--|
| 1. | Diseases caused by phosphorus or its toxic compounds. | All work involving exposure to the risk concerned. |
| 2. | Diseases caused by mercury or its toxic compounds. | All work involving exposure to the risk concerned. |
| 3. | Diseases caused by benzene or its toxic homologues. | All work involving exposure to the risk concerned. |

4.	Diseases caused by nitro and amido toxic derivatives of benzene or its homologues.	All work involving exposure to the risk concerned.
5.	Diseases caused by chromium or its toxic compounds.	All work involving exposure to the risk concerned.
6.	Diseases caused by arsenic or its toxic compounds.	All work involving exposure to the risk concerned.
7.	Diseases caused by radioactive substances and ionising radiations.	All work involving exposure to the action of radioactive substances or ionising radiations.
8.	Primary epithelomatous cancer of the skin caused by tar, pitch, bitumen, mineral oil, anthracene or the compounds, products or residues of these substances.	All work involving exposure to the risk concerned.
9.	Diseases caused by the toxic halogen derivatives of hydrocarbons (of the aliphatic and aromatic series).	All work involving exposure to the risk concerned.
10.	Diseases caused by carbon disulphide.	All work involving exposure to the risk concerned.
11.	Occupational cataract due to infra-red radiations.	All work involving exposure to the risk concerned.
12.	Diseases caused by manganese or its toxic compounds.	All work involving exposure to the risk concerned.
13.	Skin diseases caused by physical, chemical or biological agents not included in other items.	All work involving exposure to the risk concerned.
14.	Hearing impairment caused by noise.	All work involving exposure to the risk concerned.
15.	Poisoning by dinitrophenol or a homologue or by substituted dinitrophenol or by the salts of such substances.	All work involving exposure to the risk concerned.
16.	Diseases caused by beryllium or its toxic compounds.	All work involving exposure to the risk concerned.
17.	Diseases caused by cadmium or its toxic compounds.	All work involving exposure to the risk concerned.
18.	Occupational asthma caused by recognised sensitising agents inherent to the work process.	All work involving exposure to the risk concerned.
19.	Diseases caused by fluorine or its toxic compounds.	All work involving exposure to the risk concerned.

20.	Diseases caused by nitroglycerine or other nitroacid esters.	All work involving exposure to the risk concerned.
21.	Diseases caused by alcohols and ketones.	All work involving exposure to the risk concerned.
22.	Diseases caused by asphyxiants: carbon monoxide, and its toxic derivatives, hydrogen sulphide.	All work involving exposure to the risk concerned.
23.	Lung cancer and mesotheliomas caused by asbestos.	All work involving exposure to the risk concerned.
24.	Primary neoplasm of the epithelial lining of the urinary bladder or the kidney or the ureter.	All work involving exposure to the risk concerned.

PART C

1.	Pneumoconiosis caused by sclerogenic mineral dust (silicosis, anthracosilicosis asbestosis) and silico-tuberculosis provided that silicosis is an essential factor in causing the resultant incapacity or death.	All work involving exposure to the risk concerned.
2.	Bagassosis.	All work involving exposure to the risk concerned.
3.	Bronchopulmonary diseases caused by cotton flax, hemp and sisal dust (Byssinosis).	All work involving exposure to the risk concerned.
4.	Extrinsic allergic alveolitis caused by the inhalation of organic dusts.	All work involving exposure to the risk concerned.
5.	Bronchopulmonary diseases caused by hard metals.	All work involving exposure to the risk concerned.

**CHAPTER IVA
TEMPORARY DISABLEMENT BENEFIT PROCEDURE
(OCCUPATIONAL DISEASES)**

Subject				Paras No.
Introduction	...	...	...	P.4A.1
Identification of OD prone Industries – Manager’s role	...	...	...	P.4A.2 to P.4A.6
Prevention, detection & treatment of OD – IMO’s role	...	...	...	P.4A.7
A practical view of occupational diseases	...	...	...	P.4A.8
Procedure for dealing with OD sufferers	...	...	...	P.4A.9
Action on receipt of medical certificates of OD	...	...	...	P.4A.10
Reference to Special Medical Board	...	...	...	P.4A.11 to P.4A.14
OD must be supported by medical certificates	...	...	...	P.4A.15 to P.4A.16
TDB rate and date of commencement	...	...	...	P.4A.17
Claim for PDB when TDB was not claimed	...	...	...	P.4A.18 to P.4A.19
Reference not to await termination of OD	...	...	...	P.4A.20
Incapacity references	...	...	...	P.4A.21
Review by Special Medical Board	...	...	...	P.4A.22
Death of OD sufferer	...	...	...	P.4A.23 to P.4A.24
Death case must be referred to Hqrs	...	...	...	P.4A.25

CHAPTER IVA

TEMPORARY DISABLEMENT BENEFIT PROCEDURE (OCCUPATIONAL DISEASES)

Introduction

P.4A.1 This part of TDB Procedure requires special attention of every functionary employed in the administration of cash benefits under the ESI Scheme, specially the Branch Manager and the IMO. The ESI Act concerns itself mainly with the diagnosis, treatment, compensation and, where possible, recovery and return to work by an OD sufferer. Both the Branch Manager and the IMO must play a significant role not only in every aspect of the diagnosis and treatment of persons suffering from occupational diseases and perhaps save the life of many an OD sufferer but also take active measures in the prevention of these diseases.

Identification of OD prone industries - Manager's role

P.4A.2 Referring to Para 1.68 of Chapter –1-Registration, it is imperative for the Regional Office as well as the Branch Office to take all the steps laid down therein, and specially, the following: -

- (i) Survey of covered factories/establishments to identify OD prone industries.
- (ii) Distinctive registration of both OD prone industries and their employees working in OD prone processes by printing distinctive red-colour identity cards and MREs as directed in the said paragraph (or pasting red strips on both these documents for the time being).

P.4A.3 For identifying, out of the list of factories/establishments attached to each branch office, those industries which can be the cause of an occupational disease, the Manager himself can take initiative by going through the said list and attempt to identify industries/processes which may be the possible cause of an occupational disease. The Third Schedule to the ESI Act (reproduced at Annexure -I to the Law Part of this Chapter) names only the occupational diseases and it is not possible to identify the specific employments that may be the cause of each of such diseases. In the circumstances, the following Annexures have been added to this Chapter in order to assist the Branch Manager in the identification of employments that may be the possible cause of each of the said occupational diseases.

Annexure-I The First Schedule to the Factories Act, 1948, which gives a list of industries involving hazardous processes. [A hazardous process is defined in Section 2(cb) of the Factories Act as any process or activity in relation to an industry specified in its First Schedule (see Annexure – I) where, unless special care is taken, raw materials used therein or the intermediates or finished products, bye-products, wastes or effluents thereof would (i) cause material impairment to the health of the persons engaged in or connected therewith, or (ii) result in pollution of the general environment].

Annexure-II Alphabetical list of the said Schedule showing the occupational disease possibly caused by each substance/process included in the list. (only Sl. No. of each occupational disease has been given. For name of the disease, please refer to the Third Schedule reproduced at Annexure – I to the law part of this Chapter.

P.4A.4 A perusal of Annexure II will make it clear that not all the processes deemed as 'hazardous' may result in an occupational disease. This is because some processes, although being really hazardous, may be accident prone rather than OD prone. It is to be noted that Annexure II is by no means exhaustive. Further, a single substance/process may appear to be the cause of more than one occupational disease when used in combination with different substances. For example, 'Explosives' used in association with different substances are known to cause an OD at S.No. B-1, B-4, B-14, B-15, B-19, B-21 and C-2. Thus, considerable care will be needed to go through the manufacturing process/industry to find out the exact root cause of an OD suffered by an IP.

P.4A.5 It also seems relevant to point out that Annexure II, despite being in such detail, omits many of the occupational diseases mentioned in the Third Schedule to the Act. To bridge this gap, an additional list of those diseases as are caused by the industries relevant to them has been placed at Annexure III.

P.4A.6 Both Annexure II & III name the S.No. of the occupational disease caused by each industry. To determine the question whether an employment injury has been caused to an IP by an occupational disease, it will be necessary to refer to Annexures II & III and locate the S. No. of the industry mentioned in these Annexures. Once that is achieved, it will be necessary to find the name of the disease as given in Annexure I to Law Part of this Chapter. Thereafter, further inquiries will have to be made as to the process in which the person was actually employed or the process which caused the occupational disease.

Prevention, detection & treatment of OD – IMO's role

P.4A.7 As for the role of IMO, the Branch Manager should guide him as provided in para 1.68 *ibid* - (v), (vi) and (vii) thereof. IMO's role has been further emphasised/clarified through a circular dated 29th November 2004 issued by the Medical Division of Hqrs. to all State Governments, ESI Medical Directorates of each State and the concerned SMCs representing ESIC in each State. In the main, these consist of the following instructions:-

- (i) As soon as a distinctive red MRE or (one with a red strip pasted on it), is received in the dispensary, the IMO Incharge should make a reference to the ESI Hospital designated for the purpose in a specially designed reference slip for clinical examination of the IP. The reference slip should mention the IP's occupation and the OD which he is prone to suffer from and it will specify the test(s) to be performed on the IP.
- (ii) The ESI Hospital should, without delay, carry out clinical examination of all such referred persons and keep their record, X-ray and lab findings at its own level, record its observations and findings on the reference form and send it back to the concerned IMO.
- (iii) OD prone IPs, so long as they are working in hazardous employment(s), or an OD prone department of factory/establishment, will have to undergo medical examination once every year. But in those of such industries where the number of IPs exposed to hazardous processes or occupational diseases is 50% of the total strength of a factory/establishment, a six-monthly examination has been prescribed.
- (iv) The clinical data maintained in respect of these IPs should form a baseline health record and whenever any departure is noticed from the baseline data, the person involved (who may not yet be a patient needing active medical treatment and rest) should be referred immediately to the hospital for further examination.
- (v) If facilities for investigation of a particular OD are not available in the hospital, it should have tie-ups with other hospitals/institutions for getting the relevant investigation done as per the requirements of each patient.
- (vi) The IMOs would need to be given proper and need-based training on occupational diseases to enable them to be totally involved in the prevention, early detection, treatment and compensation of IPs found to be suffering from occupational diseases.
- (vii) If an IP is diagnosed or even suspected as suffering from an OD, he should be referred to the zonal occupational disease centre on the appropriate form, giving relevant details of the disease, for advice and treatment. The details of each zonal OD centre are given below:-

Occupational Disease Centre	Zone	States from which IP should be referred
ESI Hospital & Occupational Disease Centre, Basaidarapur, Ring Road, New Delhi – 110 015	North Zone	Delhi, Haryana, Punjab, Chandigarh, J&K, Himachal Pradesh, Uttar Pradesh, Uttaranchal and Rajasthan
ESI Hospital & Occupational Disease Centre, D.H. Road, P.O. Joka, Thakurpukur, Kolkata–700 104	East Zone	West Bengal, Assam, Meghalaya, Bihar, Jharkhand, Orissa
ESI Hospital & Occupational Disease Centre, Ashok Pillar Road, K.K. Nagar, Chennai – 600 078.	South Zone	Karnataka, Tamil Nadu, Pondicherry, Andhra Pradesh, Kerala
ESI Hospital & Occupational Disease Centre, 130/9, Mahannagar, Chinchwad, Pune – 411 019.	West Zone	Maharashtra, Goa, Chhatisgarh, Madhya Pradesh, Gujarat

- (viii) As soon as the disease of the IP is confirmed as an occupational disease, a report to be signed by the treating IMO will be sent by him to the Chief Inspector of Factories of the State. Such a report shall contain the following particulars of the IP: -
- (a) Name and full postal address of the patient
 - (b) The disease from which he is suffering
 - (c) The name and address of the factory in which the patient is, or was, last employed.

The above report is mandatory as required in Section 89 of the Factories Act 1948. Non-submission of such a report may attract penalty in shape of fine.

A practical view of occupational diseases

P.4A.8 If the instructions laid down for the prevention, detection, treatment and reporting of occupational diseases as given in the foregoing paragraphs are scrupulously followed, many lives could be saved and much misery in the shape of disease and loss of earning could be prevented. However, this is an ideal situation highly desirable but very difficult to achieve. Therefore, taking a practical view, there can be many OD sufferers who may seek medical treatment and disablement benefits available at a late stage when their disease has already advanced. The following paragraphs lay down the procedure for dealing with such cases.

Procedure for dealing with OD sufferers

P.4A.9 An OD sufferer will first report to his IMO and, depending on his condition at that moment, he may be issued a first certificate with which he will report to the Branch Office. He may continue to obtain and submit medical certificates, as his incapacity prolongs, with diagnosis of some commonly occurring ailment other than an OD (e. g., TB for an IP suffering from silicosis or asbestosis). But, a vigilant Branch Manager may get an inkling of the possibility that the IP may be suffering from OD from certain indications such as the following which may come to his notice and perhaps more:

- (i) Symptoms of disease which appear unusual.
- (ii) Prolonged certification.
- (iii) Sufferer complains of no relief from his treatment.

- (iv) IP is repeatedly taking sickness benefit for short intervals for an obviously genuine sickness. He says he gets sick some time after he joins duty and he gets well when he is away from his work-place.
- (v) IP suffers from skin problem or an allergy which defies all possible treatment.
- (vi) Apparently suffering from pulmonary TB, he fails to respond to TB treatment.

One or more of the above factors should set an OD conscious Branch Manager/IMO thinking and he would need answers to questions such as the following:-

- (i) Nature of the industry in which IP works.
- (ii) Various processes within his work-place.
- (iii) The period for which he has been employed and how far he has been exposed to any particular process.
- (iv) The extent to which he has been exposed to that process.
- (v) Does the process in which he works or the substance he handles, find a place in the Third Schedule to the Act (see Annexure I to Law Part) or in Annexures I, II, or III to this Chapter.
- (vi) What about other persons engaged in the process in which the OD sufferer was/is working (e. g., asbestos affects many who are forced to work on its grinding, mixing, etc.)

The Branch Manager, keeping in view the instructions on identification of ODs with reference to the industry in which a sufferer may be employed, will make detailed enquiries at the latter's workplace. His employer can also be persuaded to provide full information on the nature of employment/processes and, once this is available, all that is needed will be the clinical reports based on the tests etc. at the nearest OD centre to which IMO will refer him. If the IP's OD is confirmed at the OD Centre, it will also provide the line of treatment as well as intimate the likely period of abstention from work. IMO will then start the treatment and issue him medical certificate(s) certifying the nature of the OD the IP is suffering from.

Action on receipt of medical certificates of OD

P.4A.10 At the stage when an OD sufferer brings in a certificate confirming his disease as OD, it will be of great help to Branch Manager and the investigating official to go through the provisions of Section 52A of the Act alongwith Corporation's Resolution dated 25-2-1992 as given in the Law Part of this Chapter and to keep a note of its salient features. The procedure to be followed for investigation of OD cases is described below:-

- (1) On receipt of a certificate with diagnosis of OD shown therein, necessary enquiries should be made from the insured person to find out whether he was actually employed on any of the jobs specified in the Third Schedule and was exposed to the risks against such a disease. The statement of the insured person should also be recorded. Necessary enquiries may be made and information collected from the employer who may be requested to submit a report in respect of the insured person in Form-12A (copy at Annexure-IV).
- (2) On receipt of the said report, the investigating official should visit the factory and investigate the case thoroughly. He should examine the process which is alleged to have been the cause of OD, record statements of witnesses as well as go through employer's attendance-cum-wage record in support of the fact that insured person actually worked on the specified job for the minimum period laid down (see Part B and Part C, as the case may be, of Third Schedule).

- (3) In case any employee has put in less than the minimum service prescribed in Section 52A(1) of the Act, it should be seen whether the employee has served on the same process in any other estt. covered under the Act. If his disease falls under Part C of Third Schedule, whether the condition of the OD sufferer deserves admittance of his case as employment injury despite the period of employment being less than that prescribed for that disease.
- (4) As soon as the investigation is completed, a comprehensive report in form ESIC-25A (copy at Annexure-V) together with the details of the certificates received and other documents listed below should be submitted to the Regional Office:
 - (i) Form 12 A (Annexure IV)
 - (ii) Form ESIC-25A (Annexure V)
 - (iii) Witness statements
 - (iv) Form B.I.1
 - (v) Form B.I.1(a)
 - (vi) Form B.I.2
- (5) Until such time the Regional Office decision is available, the Branch Manager should pay sickness benefit to the insured person, if he is otherwise eligible to it, and this may be adjusted later on towards disablement benefit if the case is admitted as one of employment injury.

Reference to Special Medical Board

P.4A.11 Under Regulation 74, for a decision on the question (i) whether an IP is suffering from an occupational disease and (ii) whether the said disease has resulted in permanent disablement, every case of employment injury due to occupational disease has to be referred to a special medical board. Regulation 74 is reproduced below for ready reference:-

74. Any question whether an employment injury is caused by an occupational disease specified in the Third Schedule to the Act shall be determined by a Special Medical Board which shall examine the disabled person and send a report in such form as may be prescribed by the Director-General in this behalf to the appropriate regional office stating: -

- (a) Whether the disabled person is suffering from one or more of the diseases specified in the said Schedule ;
- (b) Whether the relevant disease has resulted in permanent disablement ;
- (c) the assessment of the proportion of loss of earning capacity and in case of provisional assessment, the period for which such assessment shall hold good .

All assessments which are provisional may be referred to the Special Medical Board for review by the appropriate Regional Office not later than the end of the period taken into account by the provisional assessment. Any decision of the Special Medical Board may be reviewed by it at any time. The disabled person shall be informed in writing of the decision of the Special Medical Board by the appropriate Regional Office and the benefit, if any, to which the insured person shall be entitled.

P.4A.12 At the Regional Office, the case will be examined by the Regional Director in consultation with the Medical Referee/SMC and referred to the Special Medical Board as required under Regulation 74. Forms to be used for this purpose (as extracted from ESIC Medical Manual) are described below:-

1) BI.8 – Specimen copy at Annexure VI.- Part I of this form will be filled in by Regional Office and Part II by treating IMO.

2) BI.9 – Specimen copy at Annexure VII – Part I will be filled in by the Branch Office and Part II will contain IP's statement which will be recorded in the same manner as described by him. He may, however, be assisted in doing so by asking questions relevant to the history of the disease he suffers from, his working environment, industry employed in, appearance of symptoms of the disease. Any test reports and connected documents brought by the IP should be enclosed to this form. Part III of this form will be exclusively filled in by the Special Medical Board.

3) BI.10- Specimen copy at Annexure VIII. This will contain the decision of the Special Medical Board, to be filled in by one of the members and signed by all its members as its Chairman.

P.4A.12A. For occupational diseases, the procedure laid down for reference to Medical Board in case of employment injury due to accident, as given in paras P.5.32 to P.5.41 – grant of permanent disablement benefits will be followed *mutatis mutandis*.

P.4A.12B. On consideration of the report of Special Medical Board on its receipt, in consultation with the MR/SMC, the case will be admitted as one of employment injury, provided the Special Medical Board has confirmed the OD of the IP. The Branch Manager should be informed immediately thereafter so as to enable him to make payment of TDB for the certified period of incapacity.

P.4A.13 If IP is found suffering from a disease included in Part 'C' of the Third Schedule for which minimum period of service is not available, the case should be decided in terms of Corporation Resolution dated 25.2.92. (See para L.4A.9)

P.4A.14 For the purpose of determining whether the total incapacity on account of occupational disease for payment of temporary disablement benefit is for not less than three days, the certified period(s) of abstention, whether continuous or broken, should be aggregated as in the case of employment injury due to accident. However, where abstention spreads over broken periods and MR/SMC is of the opinion that each period should be taken as a separate spell (i. e., as a separate accident by fresh exposure on each occasion), the total period should not be aggregated for determining eligibility to temporary disablement benefit. Each such spell shall in that event be taken as separate and dealt with accordingly.

OD must be supported by medical certificates

P.4.A15 No reference to Special Medical Board lies unless IP produces medical certificate(s) showing the cause of incapacity. Further, if the medical certificate(s) produced by the insured person do(es) not clearly indicate the diagnosis as one of OD, Regional Director should consult the MR/SMC for opinion whether the symptoms resemble those of an OD. If confirmed and recommended by MR/SMC, further enquiries should be made and case referred to Special Medical Board. In doubtful cases, a reference may be made to Hqrs. for advice.

P.4A.16 If the diagnosis mentioned in the medical certificate is not of the occupational disease and the MR/SMC also opines that the disease mentioned in the medical evidence produced has no relation to any one of the occupational diseases, the case should not be referred to the Special Medical Board. If, however, the insured person/employer/trade union insists for such a reference, despite the opinion of the MR/SMC, the Regional Director may make a reference to the Special Medical Board indicating also the viewpoint of the MR/SMC so as to enable the Special Medical Board to decide the question after being aware of the MR/SMC's opinion to the contrary.

TDB rate and date of commencement

P.4A.17 As already mentioned above, TDB is payable only after Special Medical Board admits the case as that of OD. Its rate will be determined based on commencement of the spell in accordance with the medical certificates submitted by the IP for the OD, and it will be payable from the beginning of the spell.

However, if diagnosis mentioned in the regulation certificates in the beginning of the spell or in earlier spell(s) is not clearly that of occupational disease diagnosed later on, the Special Medical Board should be consulted for opinion regarding the date of commencement of the temporary disablement for regulating the payment of benefit so far as period(s) of earlier spell(s) is/are concerned. The Special Medical Board will no doubt see whether the symptoms for the period(s) of the earlier spell(s) is/are in respect of the occupational disease itself. In case of doubt, a reference may be made to Hqrs. alongwith opinion of the Special Medical Board.

Claim for PDB when TDB was not claimed

P.4A.18 Normally, the question of payment of PDB in a case of OD without a spell or spells of temporary disablement will not arise. However, legally an odd case cannot be ruled out in which even without medical treatment and abstention on account of the OD, the IP may have been permanently disabled due to the OD. If any such claim or request is made by the insured person/employer/trade union for reference to Special Medical Board on the basis of the medical evidence and other information available, the question of reference may be decided in consultation with the Medical Referee/SMC. In doubtful cases, reference may be made to Hqrs. office for advice.

P.4A.19 In cases where PDB is payable straightaway (without any prior spell of TDB), the PDB is payable from the date of the Special Medical Board meeting unless indicated otherwise by the said Board. In doubtful cases a reference may be made to Hqrs. Office for advice.

Reference not to await termination of OD

P.4A.20 If an insured person produces regulation certificates with OD as diagnosis, it is neither necessary nor desirable to await termination of the spell of temporary disablement. This is because, as already stated, even TDB becomes payable only after Special Medical Board has decided to confirm the disease as an OD and the case has been admitted as of employment injury by the Regional Director. The payment of TDB, therefore, already suffers from inevitable delay and waiting for the termination of the spell of incapacity would further delay payment of TDB much needed by the OD sufferer.

Incapacity references

P.4A.21 The first incapacity reference in an OD case should be made after 28 days from the date of commencement of the OD spell, followed by references at fortnightly intervals. If, however, the spell has continued for over six months, a reference should be made by the Regional Director to the Hqrs. Office alongwith the opinion of the Medical Referee/SMC.

Review by Special Medical Board

P.4A.22 Quite possibly, the condition of OD sufferer in receipt of PDB may improve or he may be completely cured for reasons such as proper treatment or change of employment or nature of work. In such a case, the Branch Manager should obtain Medical Referee's opinion and refer the case to Regional Office and the Regional Office will submit papers to Special Medical Board for a review. Regulation 74 permits a review even after Special Medical Board gave its decision as to the permanent loss of earning capacity finally.

Death of OD sufferer

P.4A.23 Normally, where the Special Medical Board has finally determined loss of earning capacity under Regulation 74, it means that the disability has reached finality and that there are no chances of its being cured or further aggravated. However, chances of the IP dying on account of OD cannot be ruled out even though such chances may be remote unless other complications set in. However, whenever such cases of death arise and the dependants of the insured person make a claim for dependants' benefit, the Regional Director should make a reference to Hqrs. Office alongwith –

- (i) clinical details as recorded on the medical record envelope/card;
- (ii) post mortem report, if available; and
- (iii) Medical Referee's/SMC's opinion.

The case will be examined at Hqrs. office in consultation with Medical Division and decision taken will be conveyed to Regional Director.

P.4A.24 In case the insured person who claims to be suffering from occupational disease dies while his case is under process before he is examined by the Special Medical Board, his case may be referred to Hqrs Office for relaxation of Regulation 74, whereafter it may be referred to the Special Medical Board and, based on its finding, the Regional Director should refer the case to Hqrs. Office for consideration and decision.

Death case must be referred to Hqrs.

P.4A.25 It should be noted that every case of death due to occupational disease must be referred to Headquarters Office for acceptance in the manner stated in the preceding two paragraphs and Regional Director should not admit such a case at his own level.

THE FIRST SCHEDULE TO THE FACTORIES ACT, 1948

LIST OF INDUSTRIES INVOLVING HAZARDOUS PROCESSES

1. Ferrous Metallurgical Industries.
Integrated Iron and Steel.
Ferro-alloys.
Special Steels.
2. Non-ferrous Metallurgical Industries.
Primary Metallurgical Industries, namely zinc, lead, copper, manganese and aluminium.
3. Foundries (ferrous and non-ferrous).
Castings and forgings including cleaning or smoothening/roughening by sand and shot blasting.
4. Coal (including coke) Industries.
Coal, Lignite, Coke, etc.
Fuel Gases (including Coal Gas, Producer Gas, Water Gas).
5. Power Generating Industries.
6. Pulp and paper (including paper products) Industries.
7. Fertiliser Industries.
Nitrogenous.
Phosphatic.
Mixed.
8. Cement Industries.
Portland Cement (including slag cement, puzzolona cement and their products).
9. Petroleum Industries.
Oil Refining.
Lubricating Oils and Greases.
10. Petro-chemical Industries.
11. Drugs and Pharmaceutical Industries.
Narcotics, Drugs and Pharmaceuticals.
12. Fermentation Industries (Distilleries and Breweries).
13. Rubber (Synthetic) Industries.
14. Paints and Pigment Industries.
15. Leather Tanning Industries.
16. Electro-plating Industries.
17. Chemical Industries.
Coke Oven By-products and Coal tar Distillation products.

Industrial Gases (nitrogen, oxygen, acetylene, argon, carbon dioxide, hydrogen, sulphur dioxide, nitrous oxide, halogenated hydrocarbon, ozone, etc.)
Industrial Carbon.
Alkalies and Acids.
Chromates and dichromates.
Lead and its compounds.
Electrochemicals (metallic sodium, potassium and magnesium, chlorates, perchlorates and peroxides).
Electrothermal produces (artificial abrasive, calcium carbide).
Nitrogenous compounds (cyanides, cyanamides, and other nitrogenous compounds)
Phosphorus and its compounds.
Halogens and Halogenated compounds (chlorine, fluorine, bromine and iodine).
Explosives (including industrial explosives and detonators and fuses).

18. Insecticides, Fungicides, Herbicides and other Pesticides Industries.

19. Synthetic Resin and Plastics.

20. Man-made Fibre (cellulosic and non-cellulosic) industry.

21. Manufacture and repair of electrical accumulators.

22. Glass and Ceramics.

23. Grinding or glazing of metals.

24. Manufacture, handling and processing of asbestos and its products.

25. Extraction of oils and fats from vegetable and animal sources.

26. Manufacture, handling and use of benzene and substances containing benzene.

27. Manufacturing processes and operations involving carbon disulphide.

28. Dyes and dyestuff including their intermediates.

29. Highly flammable liquids and gases.

Alphabetical list of industries included in 1st Schedule to the Factories Act, 1948 vis-a-vis the occupational disease (OD) peculiar thereto

Nature of industry/product/mfr.	S.No. in 1 st Schedule to Factories Act.	S.No. in list of ODs as given in III rd Schedule to ESI Act.
Acetylene	17	B-2, B-21
Acids	17	A-4,B-2, B-22
Aluminium – nonferrous metallurgical industry	2	B-12, B-17,B-19
Argon Gas	17	B-22
Asbestos & its products – mfr., handling and processing of	24	B-23, C-1
Benzene, its derivatives & compounds - mfr., handling and processing of	26	B-3
Breweries (alcohol) & distilleries	12	B-21
Bromine gas	17	
Carbon dioxide gas	17	B-22
Castings & forgings in foundry industry	3	
Cement industries – Portland cement (incl. slag cement, puzzolona cement and their products	8	C-1
Ceramics	22	A-3,B-12,B-16
Chlorine gas	17	B-2, B-9
Chromates & dichromates	17	B-5
Coal (incl. coke) industries – coal, lignite, coke, etc; fuel gases (incl. coal gas, producer gas, water gas)	4	A-1, B-8, C-1
Coaltar distillation products	17	B-22
Cokeoven bye-products	17	
Copper – non-ferrous metallurgical industries	2	B-6, B-12
Detonators & fuses (for explosives)	17	See Explosives
Drugs	11	B-6,B-20,B-21
Dyes & dyestuffs incl. their intermediates	28	B-4, B-8,B-13,B-15,B-21, B-22, B-24
Electrical accumulators – mfr. & repair of	21	
Electrochemicals - magnesium, potassium, sodium; their chlorates, perchlorates & peroxides	17	
Electroplating industries	16	B-13,B-17,B-19
Electrothermal products (artificial abrasives, calcium carbide)	17	
Explosives (incl. detonators & fuses)	17	B-1,B-4,B-14, B-15, B-19,B-21,C-2
Ferrous metallurgical industries	1	
Fertilizer industries	7	B-1,B-12,C-2
Fluorine gas	17	B-19
Fungicides	18	B-6
Glass	22	B-6,B-10,B-11,B-12,B-19, B-21,C-1
Grinding or glazing of metals	23	
Halogens & halogenated compounds	17	B-9
Highly flammable liquids & gases	29	
Hydrogen gas	17	B-22

Industrial gases (carbon monoxide)	17	B-22
Insecticides	18	A-3, B-1, B-4,B-6,B-19
Iodine	17	
Iron & steel	1	
Lead & its compounds	17	A-3
Lead – nonferrous metallurgical industry	2	A-3,B-6
Leather tanning industries	15	A-1, B-5,B-12
Lignite industry	4	B-8,C-1
Lubricating oils & greases	9	
Magnesium	17	
Manganese – nonferrous metallurgical industry	2	B-12
Man-made fibre (cellulose)	20	B-21
Man-made fibre (non-cellulose)	20	B-10
Metal carbide, artificial abrasive	17	C-5
Narcotics	11	
Nitrogen gas	17	B-22
Nitrogenous compounds (cyanides, cyanamides & others)	17	
Nitrous oxide	17	A-4
Non-ferrous metallurgical industries – aluminum, copper, lead, manganese, zinc	2	Please see against each metal.
Oils & fats – extraction from vegetable and animal sources	25	B-22
Oil refining, petrochemical industries	9, 10	A-3, B-19, B-22
Oxygen gas	17	
Ozone gas	17	
Paints	14	B-3,B-12,B-13,B-17,B-21
Pesticide industries	18	A-5,B-3,B-10,B-12,B-19, B-22
Petroleum industries – oil refining, lubricating oils & greases	9	
Pharmaceuticals	11	B-4, B-13.B-18,B-21,B-22
Phosphatic fertilizer	7	B-1
Phosphrous & its compounds	17	A-5, B-1
Pigments	14	B-4,B-6
Plastics	19	B4,B-9,B-13 B-18,B-21, B-23,C-1
Power generating industries	5	
Pulp & paper (incl. paper products)	6	C-2
Puzzolona cement	8	C-1
Rubber industries	13	A-3,B-4,B-13,B-21,B-24
Slag cement	8	C-1
Smoothing/roughening by sand and shot blasting	3	
Steel, alloy steels	1	B-12,B-16
Sulphur dioxide gas	17	
Synthetic resin	19	B-21
Zinc – nonferrous metallurgical industry	2	

Additional List of OD prone industries as given in the Third Schedule to the ESI Act

Industrial process/substance	Description given in IIIrd Schedule to the ESI Act.	Remarks
Acetaldehyde	B-2,B-21	
Acetic acid mfr.	B-2	
Aircraft piston engines	B-19	
Alloys for cars, aircraft, etc.	B-17	
Animal & vegetable matter processing	C-4	
Animal debris	B-18	
Arc processes	B-11	
Artificial silk	B-2,B-10, B-21	
Asphalt	B-8	
Barometers	B-2	
Beryllium ceramics	B-16	
Blast furnaces	B-22	Asphyxiation by carbon monoxide
Boilers	B-22	-do-
Bridge building	A-2	
Butcheries, bone & bone meal	A-1	
Cadmium-nickel batteries	B-17	
Carbon disulphide	B-10	Widely used as industrial solvent.
Cardboard	C-2	
Cardiovascular drugs mfr.	B-20	
Celluloid	B-21	
Chemical weapons	B-19	
Chromium plating	B-5	
Cotton, flax, linen	C-3	
Detergents	B-1, B-3	Caused by phosphorus and its compounds Caused by Benzene and its homologues.
Dry cell batteries	B-12	
Fireworks	B-1	
Glassware etching	B-19	
High noise levels (in textiles, engg.,boilers, explosives, compressors	B-14	May result in hearing-impairment
Hot furnaces	B-11	
Hydrofluoric acid mfr.	B-19	
Hydrogen sulphide poisoning	B-22	
Inks	A-3	
Isocyanates & their derivatives	B-22	
Lasers	B-11	
Leather (synthetic)	B-21	
Methyl alcohol (methanol)	B-21	
Mineral oils	B-8	
Misc. industries, e.g., electroplating, engg.,	B-13	

leather, metals, paint, pharmaceuticals, plastics, printing, rubber, textile		
Misc. physical, chemical, biological agents, e.g., sunlight, ultra-violet rays, X-rays.	B-13	
Molten glass	B-11	
Molten metals	B-11	
Nickel plating	B-17	
Nitric acid mfr.	A-4	
Paper	C-2	
Phenol mfr.	B-3	
Perfumes	B-21	
Porcelain, pottery	C-1	
Potash permanganate	B-12	
Printing presses	A-3	
Radioactive materials manufacture (X-ray plates)	B-7	
Rayon bleaching	A-4	
Refineries	A-3	
Refractory bricks	B-5	
Rust proofing of metals	B-1	
Safety matches	B-1	
Slate pencils	C-1	
Solvents	B-21	
Storage batteries	A-3	
Textile dyeing & bleaching	B-12	
Textiles	C-3	
Thermometers	B-2	
Tunneling under water	A-2	
Urea	B-22	
Waxes (as solvents)	B-21	
X-ray clinics	B-7	
X-ray tubes	B-2	

EMPLOYEES' STATE INSURANCE CORPORATION
Report from employer in respect of an occupational disease (Reg. 68)

1. Name of the employer.....
2. Code No.....
3. (a) Name of insured person (b) Ins. No.....
4. Address of the insured person
5. (a) Age (last birthday)..... (b) Sex.....
(c) Occupation of IP..... (d) Branch Office to which attached.....
6. Name of occupational disease or its nature.....
7. Date of commencement of the occupational disease.....
8. Date of employment of insured person in the factory/establishment
9. Specific employment in which employed and its nature.....
10. Date from which the insured person was continuously working in the employment at 9 above which caused the occupational disease.....
11. The exact period of continuous employment as at 10 above before the commencement of spell of occupational disease.....
12. Date of issue of medical certificate in r/o occupational disease.....
13. Name of the disease given on the medical certificate.....
14. i) Whether the insured person has abstained from work, if so, from what date.....
ii) Has he returned to work, if so, from what date.....
15. (a) Hospital/dispensary/panel doctor from whom or where the insured person received or is receiving treatment.....
(b) Name of the dispensary/panel doctor elected by the insured person
16. Has the insured person died..... b) If so, date of death.....

I certify that, to the best of my knowledge and belief, the above particulars are correct in every respect.

Employer's name, address and code number
.....
.....
Date of despatch of report.....

Signature.....
Designation.....
(Rubber stamp)

EMPLOYEES’ STATE INSURANCE CORPORATION

Employment injury report in respect of occupational disease

Name of the Branch Office.....

Name and designation of the investigating official.....

Branch
Office
Stamp

PARTICULARS OF THE EMPLOYEE

1. Name.....2. Sex.....3. Ins. No.

4. Age.....5. Father’s/Husband’s name.....

PARTICULARS OF EMPLOYER

6. Name of factory/establishment..... 7. Code No

8. Address.....

10. Department & shift hours of the employee.....

PARTICULARS AS REPORTED BY THE EMPLOYER

11. Name of the occupational disease or its nature:
.....

12. Date of commencement of occupational disease.....
.....

13. Date of employment of insured person in factory –

a) Specific employment/process on which employed:

b) Nature of the employment:

14. Date from which the insured person was continuously working in employment at 13(a) above which caused occupational disease.....

15. Date and time of receipt of intimation

(i) by the Branch Office.....

(ii) by the investigating official.....

16. Date and time of the visit.....

FINDINGS OF THE OFFICIAL

17. Are the particulars in 11 to 14 above as reported by the employer fully corroborated by the evidence? If not, statement of facts as found by the official.
18. Is there any evidence showing that occupational disease is not an employment injury.
19. Date from which the insured person is suffering from occupational disease. Details of medical certificates or any other document should be given whereby the facts of the occupational disease are known.
20. Nature of ailment and the Part of the Third Schedule in which it is included.
21. Name of the occupational disease:-
 - (a) as per the employer's record.
 - (b) as per the records of the Branch Office.
22. (a) State the Part in which his disease is listed under the Third Schedule to the Act.
 - (b) If the insured person has contracted a disease listed in Part A of the Third Schedule, whether he was actually employed on the work specified against that particular disease. If so, since when?
 - (c) If the insured person has contracted a disease as listed in Part B of the Third Schedule to the Act, whether he was employed for a continuous period of not less than six months prior to the date of contracting the disease, i.e., before the issue of certificate with the diagnosis of the occupational disease. (Please give dates).
 - (d) Has the insured person contracted any disease specified in Part C of the Third Schedule to the Act? If so, the total service with dates with one or more employers in the employment specified against such a disease for such a continuous period as the Corporation may have specified for such employment. (See paragraph L.4A.6). Give details.
 - (e) If the IP suffering from OD included in Part C had not served for the minimum period

prescribed against the particular disease, recommendation of investigating official as to whether the case should be admitted as employment injury in the light of Para L.4A.9. (Please give reasons for your answer)

- (f) Statements of witnesses in support of (b), (c) and (d) above (to be enclosed).

23. Persons interviewed :-

Sl. No.	Name	Deptt./Shift	Residential address	Whether employment particulars confirmed
1.				
2.				
3.				
4.				

24. Whether as per the attendance register, the insured person has been abstaining from work; if so from what date?

25. Has the insured person returned to work; if so, on what date?

Note: Additional remarks, if any, may be given below or on a separate sheet attached to this statement over the signature of the investigating official.

Signature of the investigating official

EMPLOYEES' STATE INSURANCE CORPORATION
Report For Information of Special Medical Board

For the Special Medical Board meeting on.....Office and date of issue.....

PART I (TO be completed by the R.O.)

Name.....Insurance No.....
Age.....Sex.....Father/Husband's Name.....
Address.....
Name of the employer at the time of diagnosis of OD.....
Date of occurrence of OD
Date of first certificate by the IMO.....

PART II (TO be completed by the IMO)

Nature of diseases, its type and extent
.....
.....

Period of continuous treatment including } Form..... To.....
Treatment at the hospital: if any.

Brief history of the treatment given.....
Any special investigation carried out, e.g.
X-ray, pathological test, specialist opinion etc.
.....

(if so original copies of reports should be attached
.....

Date	X-ray/USG/Scan No.	Report	Remarks

The present condition of the insured person.....

Is there any coexisting condition, (e.g. any old congenital or acquired deformity) give details.

Any other relevant information.....

Date.....

Signature.....

Rubber stamp and name in block letter

To

The Chairman,
Special Medical Board.

CONFIDENTIAL

ANNEXURE-VII
FORM BI. 9
[See para P.4A.12]

EMPLOYEES' STATE INSURANCE CORPORATION

(Regulation 74)

Special Medical Board Report Form

Office and Date of issue

**DISABLEMENT BENEFIT
SPECIAL MEDICAL BOARD REPORT**

PART I-PARTICULARS OF CLAIMANT

Name.....Sex.....
Address.....
.....

Identification Marks: 1.
2.

Insurance No. Occupation.....Age.....

Description in details.....

Date of occurrence and nature of diseases.....
.....

Period of incapacity.....

Nature of incapacity leading to temporary disablement benefit

Diagnosis of any other Occupational disease

Assessment in percentage of loss of earning capacity.....

Other relevant information.....

Date

Signature

To be completed by Regional Office

PART II-CLAIMANT’S STATEMENT TO SPECIAL MEDICAL BOARD

The Statement should be as nearly as possible in the claimant’s own words and the whole record read out to him for agreement and signature below:-

I agree that the above is a correct record of my statement.

Date: _____ Signature.....

PART III-REPORT OF SPECIAL MEDICAL BOARD

- 1 Are you satisfied that the person before you is the person referred to at the Part I on Page I ?.....
- 2 General Examination
Weight..... Height..... B.P.
(state extent of clothing) (state whether with boots)
Teeth.....Mucous Membrane.....
Chest measurement Insp..... Cms. Exp.....Cms.
- 3 In the space which follows, the condition of the various systems should be described. The exact site, nature and extent of any disablement (whether resulting from occupational disease or not) from which the claimant is suffering should be noted in for as it has any effect on function as in locating a loss of faculty. If nothing abnormal is detected in any or all of the following systems, enter N.A.D. against the system.
 - a. Respiratory system.....
 - b. Alimentary system, Liver & Spleen.....
 - c. Cardio Vascular System.....
 - d. Nervous system.....
 - e. Locomotor system.....
 - f. Haemopoietic system.....
 - g. Skins.....
- 4 APPROPRIATE INVESTIGATIONS
 - a. Urine examination including special estimations.....
 - b. Blood/Serum examination including special estimations.....
 - c. Sputum examination.....
 - d. Saliva examination including special estimation.....
 - e. Bone marrow examination.....
 - f. Fundoscopic examination.....
 - g. Radiological examination.....
 - Lungs.....
 - Bones.....

- h. Biopsy Report.....
- i. Dermal tests.....
- j. Other tests.investigations.....

5 General description of claimant’s condition.....

6 Diagnosis.

7 Decision-when recording decision on the
 “disablement question” the following questions
 to be answered.

- (1). Is there ay appreciable disablement? (Yes/No)
- (2). If the answer to (1) is in the affirmative.

(a) Whether the disablement should continue to be treated as temporary disablement and if so, the next date the case should again be referred to the Special Medical Board; or

* (b) Whether the disablement can be declared of a permanent nature, if so.

- i) Whether the extent of loss of earning capacity can be assessed provisionally or finally?
- ii) The assessment of the proportion of loss of earning capacity whether provisional or final for each part affected and total LEC:
- iii) In case of a provisional assessment the period For which assessment should hold good.

* Delete whichever not applicable.

8 Remarks.

Place of Examination

Date.

SignatureChairman
Member
Member

When completed the report should kindly be returned to the Regional Office, Employees’ State Insurance Corporation at

EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 74)
DICISION OF SPECIAL MEDICAL BOARD

Insurance No.

Date:

The Special Medical Board which examined the Insured Person.....
On.....had decided that:-

*(1) there is no appropriate disablement

Or

*(2) the disablement should continue to be treated as temporary and the
next date when the case should be referred to the Special Medical Board is:

Or

*(3) the disablement can be declared to be a permanent nature and
i the extent of loss of earning capacity can be assessed
provisionally or finally;
ii the assessment of the proportion of loss of earning capacity
whether provisional of final; and
iii in case of provisional assessment, period for which it shall
hold good.

The findings of the Special Medical Board are summarized as follows:-

The decision of the Special Medical Board was not unanimous.

The recorded reasons for the dissent are:-

Signature.....
Chairman, Medical Board.

Forwarded through Regional Office to

Shri.....
.....

- * 1. If dissatisfied with the decision of Special Medical Board you may appeal to
 - i) The Medical Appeal Tribunal E.I. Court and give notice of appeal to your Regional Office within the prescribed period of communication of the decision on a form to be obtained from the Regional Office and
 - ii) to the E.I. Court directly or against the decision of the Medical Appeal Tribunal by preferring appeal with the E.I.Court on the form prescribed in the E.I. court rules within the specified period from the date of communication of decision of Special Medical Board/Medical Appeal Tribunal as the case may be. In the meantime you may claim benefit at the above rate. This is without prejudice to your right to claim benefit at a higher rate that may be awarded to you on appeal.

- 2. The decision of the Special Medical Board is not acceptable to the Corporation and a notice of appeal is being given to you separately. All the same you are entitled to claim the benefit at the above rate. This will however, be an interim payment subject to adjustment on the basis of award that may finally be made on appeal.

(Delete note (1) or (2) as appropriate)

Dated:

REGIONAL DIRECTOR

CHAPTER V

PERMANENT DISABLEMENT BENEFIT LAW

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CHAPTER V

PERMANENT DISABLEMENT BENEFIT LAW

Introduction

L.5.1. Section 46(1)(c) of the ESI Act provides for periodical payments to an insured person suffering from disablement as a result of employment injury sustained as an employee under the Act and certified to be eligible for such payments by an authority specified in this behalf by the regulations (hereinafter referred to as disablement benefit). Section 51(b) – as amended – says that subject to the provisions of this Act a person who sustains permanent disablement, whether total or partial, shall be entitled to periodical payments at such rates and for such periods and subject to such conditions as may be prescribed by the Central Government.

L.5.2. Rule 57(2) of ESI (Central) Rules, 1950, says that a person shall be qualified to claim periodical payment for permanent disablement sustained as an employee under the Act, whether total or partial, for such disablement: Provided that where permanent disablement, whether total or partial, has been assessed provisionally for a limited period or finally, the benefit provided under this rule shall be payable for that limited period or, as the case may be, for life.

Kinds of permanent disablement

L.5.3. The Act makes a distinction between a permanent total disablement and permanent partial disablement as under : -

Permanent total disablement

L.5.4. Clause (15-B) of Section 2 of the Act defines permanent total disablement as such disablement of a permanent nature which incapacitates an employee for all work which he was capable of performing at the time of accident resulting in such disablement.

L.5.5. Permanent total disablement is also deemed to result when an employee sustains an injury specified in Part-I of the Second Schedule to the Act or from any combination of injuries specified in Part-II of the said schedule where the aggregate percentage of loss of earning capacity as specified therein against those injuries, amounts to 100% or more.

Permanent partial disablement

L.5.6. Clause (15-A) of Section 2 of the Act defines permanent partial disablement as such disablement of a permanent nature which reduces the earning capacity of an employee in every employment which he was capable of undertaking at the time of accident resulting in such disablement: provided that every injury specified in Part-II of the Second Schedule shall be deemed to result in permanent partial disablement.

L.5.7. In the case of permanent total disablement the loss of earning capacity is deemed as 100% while in the case of permanent partial disablement such loss is below 100%. If more than one injury is sustained as a result of single accident and if the aggregate of the loss of earning capacity suffered as a consequence is less than 100% the permanent disablement is partial.

Aggregation of percentages

L.5.8. If a combination of injuries results from the same accident and each one individually involves permanent disablement with such a percentage as (a) each less than 100% but all collectively aggregating to over 100% or (b) 100% in case of one or each one of injuries, the loss of earning capacity thus sustained from that injury will be limited to 100% and Permanent Disablement Benefit shall be payable at the full rate.

L.5.9. In case of a fresh employment injury sustained on a later date the permanent disablement benefit, if any, payable as a result of fresh employment injury will, barring exceptions explained below, be distinct from and in addition to the PDB payable for the earlier employment injury and the two percentages will not be combined or added up for any purpose. As an illustration, an insured person was awarded 60% loss of earning capacity for amputation of right hand resulting from employment injury sustained on 1.1.03 and again 54% loss of earning capacity for loss of left eye (40%) and left great toe (14%) resulting from an employment injury sustained on 1.1.09. In this case, permanent disablement benefit for the second employment injury is payable at 54% loss of earning capacity in addition to the permanent disablement benefit admissible at 60% loss of earning capacity awarded for the earlier employment injury.

L.5.10. If insured person sustains an employment injury on the same spot a second time the percentage of loss of earning capacity awarded earlier will be adjusted against the percentage awarded for the second injury. As an illustration, if an insured person lost the distal phalanx of his right index finger and was awarded 9% loss of earning capacity and in a later accident lost the rest of his right index finger and if the loss of earning capacity was awarded at 14% for the whole finger, payment of permanent disablement benefit will be admissible only after deducting 9% awarded earlier, i. e., at the rate of 5% loss of earning capacity for the second accident. The foregoing is an important reason why details of an employment injury sustained earlier have to be provided clearly and unfailingly in Form B.1.2 for the guidance of the Medical Board so as to rule out the chances of excessive award of loss of earning capacity by them as also the resulting litigation with the insured person.

L.5.11. Part-II of the Second Schedule of the Act includes inter-alia percentages of loss of earning capacity for the loss of single limbs which have more or less similar or identical functions such as fingers and multiples of such limbs, e. g., two, three or four fingers (of the same hand). When an insured person suffers loss or amputation of multiple limbs e. g. more than one finger of the same hand, the percentage of loss of earning capacity provided in part-II 'to the' Second Schedule for the multiple limb will be admissible and not an aggregate of percentages for each single limb.

As an illustration, loss of earning capacity for amputation of both middle and index fingers of the same hand will be 20% being loss of two fingers of one hand vide item 15 and not 26% being the total of percentages given in item 33 and 37 of Part-II.

Medical Board

L.5.12. Any question -

- (a) whether the relevant accident has resulted in permanent disablement; or
- (b) whether the extent of loss of earning capacity can be assessed provisionally or finally; or
- (c) in the case of provisional assessment, to the period for which such assessment shall hold good,

shall be determined by a Medical Board constituted in accordance with the provisions of the regulations and any such question is referred to as the "disablement question" (Section 54).

L.5.13. The case of an insured person for permanent disablement benefit shall be referred by the Corporation to a Medical Board for determination of the disablement question and if, on that or any

subsequent reference, the extent of loss of earning capacity of the insured person is provisionally assessed, it shall again be so referred to the Medical Board not later than the end of the period taken into account by the provisional assessment (Section 54-A).

L.5.14. The authority to determine whether any permanent disablement has resulted from an employment injury and also whether it is to be treated as provisional or final, vests with a duly constituted Medical Board. In other words, if an insured person whose case of accident has been duly admitted as an employment injury, approaches the Branch Office or Regional Office, with a request to be referred to a Medical Board for assessment of the permanent loss of earning capacity resulting from the said accident, the Regional Office or the Branch Office has to refer him to the Medical Board even if there is no visible permanent disablement present or even if Medical Referee clearly states that this is not a fit case to be referred to the Medical Board.

Loss of teeth

L.5.15. Cases where loss of tooth/teeth occurs as a result of employment injury should be treated at par with other cases of personal injury as in that case also it is the Medical Board which is competent to decide the extent of loss of earning capacity after taking into account all the relevant factors. The Medical Board should no doubt be briefed on the distinction between functional loss resulting in loss of earning capacity and mere physical loss and to make an objective assessment in such cases.

Reference to Medical Board

L.5.16. Regulation 72 of the ESI (General) Regulations 1950 as amended says that a reference to the Medical Board may be made-

- (a) at any time not later than twelve months in cases where claim for temporary disablement benefit is made for an employment injury, from the date of the final certificate issued in respect of the spell of temporary disablement commencing on or immediately after the date of the occurrence of that injury, or from the date of occurrence of an employment injury in cases where temporary disablement benefit not having been claimed, claim for permanent disablement benefit is made on the basis thereof, by the appropriate Regional Office at the instance of the disabled person or the employer or any recognised employees' union : Provided that such reference may be made by the appropriate Regional Office after the expiry of the period prescribed as aforesaid if it is satisfied that the applicant was prevented by sufficient cause from applying for the making of the reference in time.

Provided further that in the event of the claim for temporary disablement benefit being rejected by the Corporation but afterwards granted by the Employees' Insurance Court in respect of the injuries resulting in permanent disablement, the limit of 12 months will apply from the date of the order of the Employees' Insurance Court granting the claim of the insured person for temporary disablement benefit, or

- (b) by the Corporation,
 - (i) at any time on the recommendation of an Insurance Medical Officer, and
 - (ii) on its own initiative, after the expiry of the period of twentyeight days from the first date on which the claimant was rendered incapable of work by the relevant employment injury.

In cases of delay in submission of the claim for permanent disablement benefit under clause(a) above, Regional Director/Director/Joint Director in charge of Regional Office/Sub Regional Office has been delegated full powers for relaxation of the prescribed time limit.

Report of Medical Board

L.5.17. The Medical Board shall after examining the disabled person send its decision in such form as may be specified by the Director General, to the appropriate Regional Office. The disabled person shall be informed in writing about the decision of the Medical Board and the benefit, if any, to which the disabled person shall be entitled (Regulation 73).

Constitution of Medical Boards

L.5.18. Medical Boards for the purposes of the Act shall be constituted by the Corporation and where it so desires it may approach the State Government for setting up the same. A Medical Board shall consist of such persons, have such jurisdiction and follow such procedure as the Director General may from time to time decide. (Regulation 75).

Appeal against decision of Medical Board

L.5.19. Under Section 54-A(2) of the Act, if the insured person or the Corporation is not satisfied with the decision of the Medical Board, the insured person or the Corporation may appeal in the prescribed manner and within the prescribed time to : -

- (i) the Medical Appeal Tribunal constituted in accordance with the provisions of the regulations with a further right of appeal in the prescribed manner and within the prescribed time to the Employees' Insurance Court, or
- (ii) the Employees' Insurance Court directly.

Two provisos added by the 1989 amendment of the Act have provided that –

- (a) no appeal by an insured person shall lie under this sub-section if such person has applied for commutation of disablement benefit on the basis of the decision of the medical board and received the commuted value of such benefit; and
- (b) no appeal by the Corporation shall lie under this sub-section if the Corporation paid the commuted value of the disablement benefit on the basis of the decision of the medical board.

Appeal to Medical Appeal Tribunal

L.5.20. Under Rule 20-A of the ESI (Central) Rules, 1950 insured person or the Corporation, if not satisfied with the decision of the Medical Board, may appeal against such decision to the Medical Appeal Tribunal by presenting an application within three months from the date of communication of the said decision to the insured person or the Corporation, as the case may be : provided that the Medical Appeal Tribunal may entertain an application after the period of three months if it is satisfied that the appellant had sufficient reason for not presenting the application within the said period. This application has to be in form 2 of the ESI (Central) Rules, 1950 and shall contain a statement of the grounds upon which the appeal is made. It may be sent to the Chairman of the Medical Appeal Tribunal by registered post or may be presented personally. A specimen of the form is at Annexure 'A'.

Appeal to Employees' Insurance Court

L.5.21. Under Rule 20-B of the ESI (Central) Rules, 1950 an insured person or the Corporation may appeal to the Employees' Insurance Court by presenting an application within three months of the date of communication of the decision of the Medical Board or of the Medical Appeal Tribunal to the insured person or the Corporation, as the case may be : provided that the Employees' Insurance Court may entertain an application after the period of three months if it is satisfied that the appellant had sufficient reasons for not presenting the application within the said period. In respect of the form and manner to be

followed in presenting application, the rules made by the State Government on this behalf will have to be followed.

Rate of permanent disablement benefit

L.5.22. In case of permanent total disablement, the daily rate of benefit will be full rate, i.e., the rate of temporary disablement benefit.

L.5.23. In case of permanent partial disablement, the daily rate of benefit will be such percentage of the full rate corresponds to the percentage reduction in the earning capacity of the disabled person as assessed by a Medical Board. As an illustration, for the loss of a thumb, the percentage loss of earning capacity has been stated as 30% (Item 11 of the Second Schedule). The daily rate of permanent disablement benefit will be 30% of the full rate of temporary disablement benefit.

Increase in rates of permanent disablement benefit

L.5.24. In order to compensate the erosion in real value, the Corporation has, from time to time, sanction increases in basic rates of permanent disablement benefit as under :-

Table I
Table of enhancement of permanent disablement benefit rates

Date of employment injury		Increase in basic rate of benefit allowed from				
		1-10-77	1-4-80	1-1-87	1-1-89	1-1-92 (See note 1 below)
(a)	On or before 31-3-74	20%	20%	45%	10%	45%
(b)	1-4-74 to 31-3-75	10%	20%	45%	10%	35%
(c)	1-4-75 to 31-3-78	--	15%	45%	10%	35%
(d)	1-4-78 to 31-3-79	--	--	45%	10%	35%
(e)	1-4-79 to 31-3-81	--	--	35%	10%	30%
(f)	1-4-81 to 31-3-84	--	--	15%	10%	30%
(g)	1-4-84 to 31-12-86	--	--	--	10%	25%
(h)	1-1-87 to 31-3-90	--	--	--	--	15%

L.5.25. In addition to the increases mentioned in the table given above, the Corporation has affected six more increases and in each case the periods mentioned in the first column in the above table were spread over to a very great extent and each period was given a separate increase. Details of these increases are given below: -

Table II

Period		No. of slabs	Increase ranges from		Date from which effective
From	To		Lowest	Highest	
Upto 31-12-52 or before	1-1-91 to 31-12-91 (40 th slab)	40	8%	706%	1-1-93
-Do-	1-1-92 to 31-12-92 (41 st slab)	41	10%	977%	1-4-95

Upto 31-12-52 or before	1-1-95 to 31-12-95	44	11%	2085%	1-8-97
- Do -	1.1.97 to 31.12.97 (46 th slab)	46	14%	2359%	1.8.99
- Do-	1.1.99 to 31.12.99 (49 th slab)	49	7%	2689%	1.8.2002
- Do-	1.1.2001 to 31.12.2001 (50 th slab)	50	7%	3119%	1.8.2005

The rates given in the aforesaid three increases in Table II above are inclusive of all the previous increases allowed, as given in the Table I above.

Note 1: The full rate of PDB after enhancement should not exceed the maximum full rate of TDB which was -

Rs. 18.75 upto 31-12-80

Rs. 21.00 from 1-1-81 to 26-1-85

Rs. 28.00 w. e. f. 27-1-85

However, the maximum limits as stated above are not applicable to increases in PDB rates sanctioned after 1.1.89.

Note 2 : When fractions of paise occur in the increased rates, these should be rounded off to two decimal points, e. g., 35.9375 paise to 35.94 paise and 10.8635 paise to 10.86 paise.

Note 3 : The quantum of enhancement in PDB rates upto the increase effected on 1-1-92 is to be allowed with reference to the date of employment injury and not with reference to the date of commencement of PDB. However, the quantum of enhancement effected from 1-1-93, 1-4-95 and 1-8-97 is to be allowed with reference to the date of commencement of PDB of an insured person due to employment injury.

Note 4 : The increase in PDB rates is to be allowed on the "basic amount". Basic amount means PDB rate which was originally payable before allowing any increase.

Note 5 : For calculation of actual PDB rate under each slab admissible on account of the three increases sanctioned *vide* Table II above, Hqrs. Memos, copies of which were supplied to all the Branch Offices, have to be referred to.

L.5.26. As stated in para L.5.2 permanent disablement benefit, total or partial, is payable to the insured person for life, except in the case of provisional assessment when it is payable for the period covered by the provisional assessment only or as stated in para P.5.41 of Permanent Disablement Benefit Procedure.

Date from which payable

L.5.27. Permanent disablement benefit will be payable –

- (a) from the date of termination of temporary disablement for employment injury resulting from an accident, if such disablement has ended before the date of decision of the Medical Board, or

(b) from the date of Medical Board examination, whichever is earlier.

L.5.28. As regards the date from which permanent disablement benefit should be paid in cases where temporary disablement benefit is suspended due to some reason e.g. insured person's failure to appear before the Medical Referee for examination under Regulation 105, permanent disablement benefit is payable from the date temporary disablement (and not TDB) ceases. Temporary disablement can be said to have ceased only from the date on which the insured person is certified to be fit. It follows that no benefit is payable for any period preceding the date of fitness for which temporary disablement benefit may have been suspended.

L.5.29. If the insured person has not abstained from work and has not been certified temporarily disabled as a result of employment injury at any time between the date of employment injury and the date of assessment by the Medical Board, permanent disablement benefit, if assessed, will be payable from the date following the date of employment injury due to accident. This will include a rare case in which IP's accident case was admitted as employment injury and the IP abstained from work on medical grounds but took treatment on his own and never claimed TDB.

When claim becomes due

L.5.30. Regulation 45 (c) says that for the purpose of Section 77 of the Act a claim for the first payment of permanent disablement benefit becomes due on the date on which an insured person is declared as permanently disabled. Since Medical Board is the authority to determine the disablement question under Section 54 of the Act, the period of limitation as specified in Sec. 77 begins from the date an insured person is declared permanently disabled by a duly constituted Medical Board.

When claim becomes payable

L.5.31. As per Regulation 52, the first payment of permanent disablement benefit will be made not later than one month after the claim therefore with the relevant papers complete in all respects has been furnished to the Branch Office. The subsequent payments whether these are for whole month or part thereof, are to be made within the calendar month following the month to the whole or part of which they relate, whichever is later, subject to production of any documentary evidence that may be called for, e.g., a life certificate, etc.

L.5.32. If a benefit payment is not made within the above time limits, it shall be reported to the Regional Office and must be made as early as possible (Regulation 52).

L.5.33. For the purpose of time limits for payment, claims for commuted value of permanent disablement benefit have to be treated at par with claims for first payment of the periodical payments of this benefit. In other words, payment of commuted value has to be made within one month of the date on which the claim therefore together with the relevant papers complete in all respects has been furnished to the Branch Office.

Place of first payment

L.5.34. As per Regulation 107-B read with instructions on the procedure for payment of permanent disablement benefit, the Branch Office will not make the first payment of permanent disablement benefit by money order and should insist upon the insured person to come to the Branch Office. The said regulation provides that the Branch Manager may require personal attendance and due identification of any person claiming permanent disablement benefit not more than once every six months, the only exception to this being a person incapacitated by bodily illness or infirmity or a purda nashin lady. A person suffering from permanent total disablement who is unable to come to the Branch Office even for the first payment can, as per instructions on the subject, be paid benefit at his place of residence personally by the cashier of the nearest Branch Office.

L.5.35. Subsequent payments of permanent disablement benefit can be made in cash at a Branch Office or by means of postal money order on the option of the claimant. This also is subject to provisions of Regulation 107-B mentioned in the foregoing paragraph.

L.5.36. Every person who claims or is in receipt of disablement benefit must either (i) submit himself to a medical examination as directed by the appropriate Regional Office for the purpose of determining the effect of employment injury or treatment appropriate to the injury or loss of faculty, or (ii) attend any vocational training courses or industrial rehabilitation courses provided by any institutions maintained by any government, local authority or any public or private body recognised for the purpose by the Corporation and considered appropriate by it in his case (Regulation 71).

Commutation

L.5.37. Regulation 76-B which regulates the procedure for commutation of permanent disablement benefit into lump sum, and which was amended w.e.f. 19.4.2003, states as under : -

- (1) An insured person whose permanent disablement has been assessed as final and who has been awarded permanent disablement benefit at a rate not exceeding rupees five per day may apply for commutation of periodical payments of permanent disablement benefit into a lump sum .

PROVIDED that the insured person whose permanent disablement has been assessed as final and the benefit rate exceeds Rs. 5.00 per day may also apply for commutation of permanent disablement benefit into lump sum subject to the condition that the total commuted value of the lump sum permanent disablement benefit does not exceed Rs. 30,000 at the time of commencement of final award of his permanent disability:

PROVIDED FURTHER that the cases falling under clause (3) of this Regulation where commutation has been refused because the insured person did not have average expectation of life, shall not be reopened.

- (2) Where such an application made within six months of the date on which an insured person can opt for commutation, hereafter called the “date of possible option”, the permanent disablement benefit shall be commuted into a lump sum.
- (3) Where such an application is made after expiry of six months from the date of possible option, the permanent disablement benefit may be commuted into a lump sum if the Corporation is satisfied that the insured person has an average expectation of life for his age. For this purpose, the insured person shall, if so required by the appropriate office, present himself for examination by such medical authority as the Director-General may, by general or special order, specify.
- (4) The date of possible option means the date on which assessment of permanent disablement by Medical Board is communicated to the insured person by the appropriate Regional Office.
- (5) The amount of lump sum admissible shall be determined by multiplying the daily rate of permanent disablement benefit by the figure indicated in column 2 of Schedule III to the Employees’ State Insurance (General) Regulations, 1950, corresponding to the age on last birthday of the insured person on the date on which his application for commutation is received in the appropriate office and on and from that date the permanent disablement benefit shall cease to be payable to him: Provided that where no proof of age has been submitted as required by the appropriate office or, if submitted, has not been accepted as satisfactory by the appropriate office, the corresponding age as aforesaid of the insured person shall be the age as estimated by the Medical Board on the date of examination adjusted by the period intervening between the date of examination by the Medical Board and the date on which the application for commutation was received in the appropriate office.

Provided further that the age so estimated by the Medical Board shall also operate against any proof of age that may be submitted after the time allowed for the purpose to the insured person by the appropriate office before reference of his case to the Medical Board.

Date of possible option

L.5.38. As per provisions of Regulation 76-B(4) and clarified by Hqrs. instructions issued from time to time, date of possible option is determined as follows : -

- (i) Whenever any increase in the monetary limit for the purpose of commutation of permanent disablement benefit is notified, whereby insured person in receipt of disablement benefit at a daily rate higher than the earlier limit becomes entitled for commutation, date of coming into force of the amended regulation with the higher monetary limit is the date of possible option from which 6 months' period will be counted.
- (ii) In other cases : -
 - (a) If the Medical Board assesses loss of earning capacity finally as more than zero percent, the date of communication of this assessment by Regional Office is the date of possible option.
 - (b) If the Medical Board assesses zero percent loss of earning capacity and the insured person appeals against his assessment to a Medical Appeal Tribunal/Employees' Insurance Court and the Medical Appeal Tribunal/Employees' Insurance Court awards him some percentage, the date of possible option will be the date of communication of decision of Medical Appeal Tribunal/Employees' Insurance Court by the Regional Office.
 - (c) If the insured person appeals against a Medical Board assessment of more than zero percent or if the Corporation appeals against an award which it considers excessive and the earlier award of Medical Board is enhanced or reduced or remains unchanged on appeal as the case may be, the date of possible option in both these cases will be the date on which the Regional Office originally communicated the decision of Medical Board to the insured person.

The position as stated above read "date of possible option" will also apply in cases of commutation falling under first proviso to sub-regulation (1) of Regulation 76B vide para L.5.37 above.

Commutation when daily PDB rate exceeds Rs. 5.00

L.5.38A. The facility of commutation in cases where PDB rate exceeds Rs. 5.00 per day but total commuted value does not exceed Rs. 30,000/- would be available only in those cases in which final award has been given by the Medical Board on or after 19-4-2003.

L.5.38B. It is clarified that for eligibility to commutation of PDB where the daily rate of benefit exceeds Rs. 5.00, the extent of commuted value is to be calculated with reference to the date of commencement of final award of permanent disability i. e., the date of decision of Medical Board awarding loss of earning capacity finally. In other words, the age on last birthday of the claimant is to be determined with reference to the date of examination by the Medical Board and he will be allowed commutation if the commuted value of his PDB does not exceed Rs. 30,000/-.

L.5.38C. Branch Manager may need to calculate whether commuted value will be within the ceiling of Rs. 30,000/-. He will find it easy to do so by reference to Annexure 'B' of this Chapter which is reproduced from Schedule III of the Regulations. As this has been added, a ready reckoner of daily rates at different ages each of which, when calculated, will come to less than Rs. 30,000/-. Branch Manager can instantly find an answer to the question whether a daily PDB rate in excess of Rs. 5.00 can be commuted.

For example, an IP whose age on his last birthday is determined as 27 years at the time of Medical Board examination, will be eligible to commutation only if the rate of his PDB does not exceed Rs. 6.05 per day. Similarly, an IP whose age is determined as 59 years on his last birthday can get his commutation only if his PDB rate does not exceed Rs. 9.25 per day.

L.5.38D. Commuted value not exceeding Rs. 30,000/- will depend on 3 factors, namely, (i) age on last birthday (which goes on increasing every year), (ii) commutation factor which goes on reducing as one gets older, and (iii) daily rate of PDB which remains constant. It is quite possible that daily rate of PDB may not allow commutation (e. g. Rs. 6.00 at age 24 years last birthday), but as years pass, the commutation factor gets reduced and commutation may become feasible. In the foregoing case cited, commutation will be admissible as soon as the IP crosses his 25th year. In such a case also, commutation will be admissible, provided. –

- (i) IP passes the test of average life expectation if six months have already passed since the award.
- (ii) No *ad hoc* increase was sanctioned by the Corporation in the meantime thus raising his daily PDB rate.

Bar against appeal

L.5.39. Once commutation has been applied for and paid, both insured person and the Corporation are barred against an appeal *vide* Section 54A of the Act as amended. See also para L.5.19 above.

Proof of age

L.5.40. A reading of the first proviso to the sub-Regulation (5) *ibid* implies that before his case is referred to Medical Board, the insured person should be asked by the Branch Office to submit proof of his age. It also states that if no proof has been submitted or the proof submitted has not been found acceptable, his age will be got assessed by the Medical Board at the time of his examination for assessment of loss of earning capacity resulting from his employment injury. This proviso entails an important duty on the Branch Office to seek from the insured person the proof of his age before referring the case to Medical Board. Where age-proof is not submitted or, if submitted has not been considered satisfactory, then the age determined by Medical Board will, as per second proviso, hold good against any proof of age that may be submitted by the insured person in respect of either the claim in process or any subsequent claim arising from a later employment injury.

L.5.41. As per Regulation 80 which is applicable by implication to cases of permanent disablement benefit seeking to obtain commuted value of their claims, the following may be accepted by the Corporation as proof of age : -

- (a) Certified extract from an official record of births showing the date and place of birth and father's name.
- (b) Original horoscope prepared soon after birth.
- (c) Certified extract from baptismal register.
- (d) Certified extract from school record showing the date of birth and father's name.
- (e) Such other evidence as may be acceptable to the appropriate Regional Office in the circumstances of a particular case.

Constitution of Medical Appeal Tribunals

L.5.42. Under Regulation 76, the State Government shall constitute as many Medical Appeal Tribunals as it thinks fit. Each such Medical Appeal Tribunal shall consist of such persons, exercise such jurisdiction and follow such procedure as the State Govt., in consultation with the Corporation may, from time to time, decide.

L.5.43. For the sake of uniformity, the ESI Corporation has recommended to the State Govts. that Medical Appeal Tribunals may have the following constitution :-

The Medical Appeal Tribunal shall consist of –

- (i) a person who is or has been a judicial officer of a State Govt. or a legal practitioner of 3 years' standing or is a Commissioner for Workmen's Compensation being a person other than the judge of the E. I. Court (the presiding officer/chairman should not be of a status higher than the Judge of the E. I. Court) as Chairman.
- (ii) One or more medical experts, and
- (iii) One or more officials or members of trade union or unions.

Review of decision by Medical Board or Medical Appeal Tribunal

L.5.44. Under Section 55 of the Act a decision given by a Medical Board or a Medical Appeal Tribunal can be reviewed by the Medical Board or M. A. T., as the case may be, at any time if fresh evidence is brought before it having bearing on the case. No time limit is provided in such cases.

Cases of assessment of loss of earning capacity may also be reviewed by a Medical Board on the expiry of a period of five years in case of final assessment and 6 months in case of provisional assessment from the date of the earlier assessment if the Medical Board is satisfied that substantial and unforeseen aggravation has taken place since the earlier assessment. To make a Medical Board examine a case of aggravation earlier than the period aforesaid, the permission of Medical Appeal Tribunal will have to be obtained. The section also clarifies that the revised assessment of loss of earning capacity, if awarded on review, will be effective only from the date of application by the insured person and not from an earlier date.

Subject to the above provision, Medical Board will deal with a case of review in the same manner as with a fresh case and will decide the disablement question. Further, the review decision of the Medical Board will also be applicable in the same manner as a decision on original case.

L.5.45. Insured persons who have received commuted value of permanent disablement benefit cannot avail of the provisions contained in Section 55. Hence there is no question of review of the earlier assessment in such cases even when any aggravation is claimed to have taken place in the earlier employment injury for which commuted value of permanent disablement benefit has been already paid.

Time limits for enforcing claim for benefit

L.5.46. Under section 77 of the Act an application to the EI Court has to be made within a period of three years from the date on which the cause of action arose. For this purpose, the cause of action in respect of a claim for benefit is not deemed to arise unless the insured person claims that benefit in accordance with the relevant regulations within a period of 12 months after the claim became due or within such further period as the E. I. Court may allow on grounds which appear to it to be reasonable. As stated in para L.5.30, claim for permanent disablement benefit becomes due under Reg. 45 on the date an insured person is declared as permanently disabled.

L.5.47. Sub-section (2-A) of Section 75 says that if in any proceedings before the Employees' Insurance Court a disablement question arises and the decision of a Medical Board or a Medical Appeal Tribunal has not been obtained on the same and the decision of such question is necessary for the determination of the claim or question before the Employees' Insurance Court, the court shall direct the Corporation to get the insured person examined by the Medical Board or Medical Appeal Tribunal for a decision first, whereafter it will proceed with deciding his claim or question. The foregoing provision is meant to help the person whose accident has not been admitted as employment injury by the Corporation and who approaches the Employees' Insurance Court for payment of temporary and/or permanent disablement benefits. Once the Court feels that the claim for permanent disablement benefit is justified, it will issue directions to the Corporation to get the claimant examined by a Medical Board for assessment of loss of earning capacity and on receipt of its decision, the court can determine the claim for permanent disablement benefit. This sub-section also makes an implied provision that even in such cases, the insured person, if not satisfied with the decision of the Medical Board can appeal to the Medical Appeal Tribunal and on obtaining the award of the M. A. T., approach the Employees' Insurance Court for deciding his claim for permanent disablement. In actual practice, however, if the court simply admits the claim of employment injury, the Corporation has to take the rest of the action on its own initiative, i. e., payment of temporary disablement benefit, reference of the case to Medical Board, etc.

Authority for certifying eligibility

L.5.48. The authority which has to certify the eligibility of a claimant to permanent disablement benefit is the appropriate Regional Office (Regulation 51).

Claims for periodical payments

L.5.49. An insured person who has been declared to be permanently disabled by a Medical Board or by a Medical Appeal Tribunal or an Employees' Insurance Court is required to submit by post or otherwise to an appropriate Branch Office a claim for PDB covering, except in the case of a first payment, a period of one or more complete calendar months in form-14. (Regulation 76-A).

Claim for commuted value

L.5.50. In respect of form of claim for commuted value, modified form 14 will be obtained from each insured person on receipt of sanction of his commuted value from Regional Office.

Six monthly certificate

L.5.51. Every person whose claim for any permanent disablement benefit has been admitted is required to submit at six monthly intervals with the claim for December and June every year, a certificate in Form-23 (w.e.f. 1.1.2005) attested by such authority or person and in such manner as may be specified by the Director General (Regulation 107). A certificate signed by any one of the authorities mentioned below given over his seal or rubber stamp will be acceptable :-

- (i) An officer of the Revenue, Judicial or Magisterial Department.
- (ii) A Municipal Commissioner.
- (iii) A workmen's Compensation Commissioner
- (iv) The Head of gram Panchayat under the official seal of the Panchayat
- (v) An M.L.A./M.P.
- (vi) A Gazetted Officer of Central /State Govt..
- (vii) A member of the Regional Board/Local Committee of the ESIC.
- (viii) Any other authority considered appropriate by the Branch Office Manager concerned.

Medical care to the permanently disabled

L.5.52. Proviso to Regulation 103 says that after the disablement has been declared as a permanent disablement, the person shall not be entitled to medical benefit, if he is not otherwise entitled to such benefit, except in respect of any medical treatment which may be rendered necessary on account of the employment injury from which the disablement resulted. In other words, if a person whose disablement has been declared as permanent leaves insurable employment and thereby contributions in respect of whom cease to be payable, his entitlement to medical benefit would cease after a lapse of a certain period as provided in Regulation 103A.

L.5.53. With a view to extending medical care to this category of insured persons as well as to those who retired from active employment on superannuation, the ESI Act was amended effective from 1-2-1991, followed by amendment to ESI (Central) Rules, 1950 and the ESI (General) Regulations, 1950 whereby both the above categories of persons (and their spouses) will be able to avail of medical care on payment of a nominal fee and subject to certain conditions. Detailed provisions of the law and the procedure for this benefit may be seen in Chapter XII of this Manual.

FORM 2

[SEE Rule 20A(2) of the ESI (Central) Rules,1950]

Application to Medical Appeal Tribunal

Insurance No. _____

I(full name of appellant)
of
(Address of appellant) appeal against the decision on (date)
of the Medical Board at(Address) notified to me by letter
(from) date that :-

- * (1) there is no appreciable disablement.
- * (2) this disablement should continue to be treated as temporary and the next date when the case should be referred to the medical Board is _____ ; or
- * (3) the disablement can be declared to be of a permanent nature and –
 - (i) the extent of loss of earning capacity can be assessed provisionally or finally;
 - (ii) the assessment of the proportion of loss of earning capacity whether provisional or final; and
 - (iii) in case of a provisional assessment, the period for which such assessment shall hold good.
 - (iv)

The following are the grounds of my appeal:-

List of documents, if any.

Date _____

Signature of the appellant _____

The statement of facts contained in this application is, to the best of my knowledge and belief, true and correct.

Date _____

Signature of the appellant _____

To

Chairman of Medical Appeal Tribunal. _____

* Delete whichever does not apply.

ANNEXURE 'B'
(see paras L.5.38A to L.5.38D)

Schedule III to ESI (General) Regulations, 1950
Daily rate calculated so that commuted value does not exceed Rs. 30,000/-

<i>Age last birthday (in years)</i>	<i>Commutation factor</i>	<i>Daily rate does not exceed</i>
17 and below	5690	5.27
18	5670	5.29
19	5660	5.30
20	5640	5.31
21	5620	5.33
22	5600	5.35
23	5580	5.37
24	5560	5.39
25	5540	5.41
26	5510	5.44
27	5480	5.47
28	5460	5.49
29	5420	5.53
30	5390	5.56
31	5360	5.59
32	5320	5.63
33	5280	5.68
34	5240	5.72
35	5200	5.76
36	5160	5.81
37	5110	5.87
38	5070	5.91
39	5020	5.97
40	4970	6.03
41	4910	6.10
42	4860	6.17
43	4800	6.25
44	4740	6.32
45	4670	6.42
46	4610	6.50
47	4540	6.60
48	4470	6.71

<i>Age last birthday (in years)</i>	<i>Commutation factor</i>	<i>Daily rate does not exceed</i>
49	4400	6.81
50	4330	6.92
51	4250	7.05
52	4180	7.17
53	4100	7.31
54	4020	7.46
55	3930	7.63
56	3850	7.79
57	3760	7.97
58	3670	8.17
59	3590	8.35
60	3500	8.57
61	3400	8.82
62	3310	9.06
63	3220	9.31
64	3130	9.58
65	3030	9.90
66	2940	10.20
67	2850	10.52
68	2750	10.90
69	2660	11.27
70	2570	11.67
71	2470	12.14
72	2380	12.60
73	2290	13.10
74	2200	13.63
75	2120	14.15
76	2030	14.77
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78	1860	16.12
79	1780	16.85
80	1700	17.64

CHAPTER V

PERMANENT DISABLEMENT BENEFIT PROCEDURE

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CHAPTER V

PERMANENT DISABLEMENT BENEFIT PROCEDURE

Termination of temporary disablement

P.5.1. A claim for permanent disablement benefit will arise when an employment injury resulting from an accident or occupational disease has reached a stage where temporary disablement has to be terminated either because of recovery or because treatment and abstention from work is no longer necessary or feasible. An insured person left with residual permanent disability after treatment has to be examined by a Medical Board to decide the disablement question. In most cases, an employment injury first results in temporary disablement, whereafter residual permanent disablement may be present. However, residual permanent disablement may also occur in an isolated case where the insured person, after his employment injury, did not abstain from work and, therefore, did not avail of any temporary disablement benefit.

P.5.2. Before a case becomes due for reference to Medical Board, it should normally pass through the following stages:

1. Receipt of accident report from employer, its investigation and admittance as employment injury in accordance with the procedure laid down.
2. Receipt of medical certificates and also the final certificate or termination of temporary disablement by Medical Referee.
3. Payment of temporary disablement benefit due.
4. Receipt of recommendation from IMO/IMP or a request by or on behalf of the insured person or decision by Branch Manager himself for reference to Medical Board.

Detailed procedure for cases of occupational diseases may be seen in Chapter IV A

Procedure in case of occupational disease

P.5.3. For persons suffering from occupational disease, the position is different in that the medical certificates generally precede a report from the employer on the occupational disease in form 16A; further, even the temporary disablement benefit can be paid only after Regional Office accepts the case as of employment injury on the recommendation of the Special Medical Board. The Special Medical Board, on receipt of a reference from the Regional Office, normally decides both the questions together,, namely:

- (i) Whether the insured person was suffering from an occupational disease during the period for which he has submitted certificates of incapacity and
- (ii) whether there is any residual permanent disablement arising from the occupational disease and, if so, the percentage of loss of earning capacity suffered by him.

Detailed procedure for cases of occupational diseases may be seen in chapter IVA.

Procedure in Accident cases

P.5.4. In accident cases, the treating IMO will normally recommend reference to Medical Board by adding the following or similar remarks in the final certificates under his signatures:

“Temporary disablement terminated. Reference to Medical Board recommended.”

P.5.5. All references to the Medical Board in case of claim for permanent disablement benefit arising out of accident will be made by the Regional Office. Such reference may be made –

- (i) at any time, on the recommendation of an IMO/IMP; or
- (ii) on its own initiative (which includes reference from the Branch Office) after expiry of a period of 28 days from the first day on which the claimant was rendered incapable of work by the relevant employment injury; or
- (iii) at any time at the instance of the disabled person; or
- (iv) at any time at the instance of the employer of disabled person; or
- (v) at any time at the instance of any recognised employees' union.

Reference by Branch Office

P.5.6. This has been provided to keep in check any unnecessary prolongation of temporary disablement. A continuous watch has to be kept by the Branch Office over cases of prolonged temporary disablement. Incapacity references in such cases should be initiated strictly in accordance with Headquarters instructions. But, the Branch Office should not make a reference to Medical Board unless the temporary disablement is terminated. Where temporary disablement has lasted for six months, a specific reference may be made to Medical Referee, alongwith relevant details, asking him whether reference of the case may be made to the Medical Board. But, as already stated, reference to Medical Board cannot be made unless temporary disablement is terminated either by the Medical Referee or by the IMO.

P.5.7. Reference will ordinarily be made by the Regional Office on the initiative of the Branch Office. As far as possible, the Branch Manager may at times and also on final payment of temporary disablement benefit interview the insured person in order to ascertain the exact position whether temporary disablement should cease or permanent disablement has resulted or is likely to result. In case permanent disablement is obvious, he may obtain a written request from the insured person if he so desires for reference to Medical Board. In a doubtful case, the Branch Manager may refer him to the Medical Referee for his opinion whether any residual disablement exists which calls for assessment by Medical Board. A reference to Medical Referee may also be made in cases where Medical Board documents and other relevant papers/information are incomplete or missing.

Procedure for reference

P.5.8. As soon as a request/recommendation is received and/or a decision is taken for referring an insured person to Medical Board, an entry should be made in the register of references to Medical Board in form ESIC-61-copy at annexure I so as to watch the progress of each case. The register will be reviewed every week by the Branch Manager so as to bring to light any bottleneck calling for urgent action. A summary of the cases may be drawn up at the end of every month in the following proforma.

1. Number of cases pending for reference to Regional Office as on the first day of the month.
2. Number of fresh cases during the month.
3. Total.
4. Number of cases referred to Regional Office during the month.
5. Balance of cases yet to be referred to the Regional Office.
6. Break-up of cases at column 5 pending at Branch Office :-
 - (i) Cases pending upto one month.

- (ii) Cases pending over one month but upto two months.
 - (iii) Cases pending over two months but upto three months.
 - (iv) Cases pending over three months.
 - (v) Remarks.
7. Number of cases in which decision received during the month out of the above.
 8. Number of cases wherein first payment made during the month.
 9. Balance pending at Regional Office.
 10. Break-up of cases pending with Regional Office as per item 9:
 - (i) Cases pending upto one month.
 - (ii) Cases pending over one month but upto two months.
 - (iii) Cases pending over two months but upto three months.
 - (iv) Cases pending over three months.
 11. Remarks.

Note: Serial numbers of the register of pending cases may be indicated against the break-up

Documents to accompany reference – Check List

P.5.9. The Branch Office should send the following documents to Regional Office in respect of every case requiring reference to the Medical Board:

- (a) Accident Report – Form 16 (renumbered as form 12 w.e.f. 1.1.2005)
- (b) Original or attested copy of ESIC-25
- (c) B.I.1 (a) in original alongwith B.I.1 if available or certificates, hospital discharge certificate in case the insured person was an in patient in a hospital.
- (d) Verified ESIC-32/ESIC-71 or certified extract of return of contributions.
- (e) Medical Referee’s report, if any, having a bearing on the case including his opinion regarding advance payment of permanent disablement benefit.
- (f) Period of incapacity: in case of relapse, details of all spells. Care should be taken to inform Regional Office immediately in case relapse of employment injury occurs after papers have been despatched to Regional Office.
- (g) History of previous employment injury, if any, showing the exact location, nature and date, etc. of the same insured person decided earlier or for which a decision is awaited.
- (h) Name of treating IMO and the dispensary to which attached.
- (i) Latest complete address of the insured person where he is sure of receiving Regional Office communication.
- (j) A written clarification from insured person explaining reasons for delay in claiming permanent disablement benefit (required only in cases where delay is more than 12 months).

- (k) Proof of age in original alongwith an electrostat copy thereof. (The original will be returned by Regional Office). In case proof of age is not available, an application from the disabled insured person for determination of age by the Medical Board (See annexure III).
- (l) Any other statement or data required by Regional Office.

P.5.10. As regards items (a) and (b) above, if the case was investigated earlier and submitted to Regional Office for admittance as employment injury, both Form 12 and ESIC-25, together with other relevant papers would have been retained in Regional Office, in which case the forwarding letter from Branch Office should clearly mention the number and date of Regional Office Memo in which its decision was conveyed to the Branch Office.

P.5.11. There may be a few accident cases which, on the basis of the particulars given in the accident report, the B.I.1 and/or the medical certificates, were admitted by the Branch Manager initially without investigation under his own powers, but the need for referring them to the Medical Board has arisen only later on. Such cases need not be investigated subsequently and these too may be referred to Regional Office for Medical Board examination with suitable remarks in the forwarding letter. Form 12, etc. may be enclosed in such cases.

P.5.12. As regards item (c) of para P.5.9 above, B.I.1 (a) is a very important document which helps the Medical Board to come to a just assessment of loss of earning capacity of an insured person. The B.I.1 (a) form should be issued (after filling in part I) for completion within 3 days of receipt of request/recommendation for Medical Board reference. Immediate return of this form should be ensured and, if necessary, by the personal visit of a Branch Office official.

Wage verification/rate checking

P.5.13. As regards item (d) of para P.5.9 above, the following procedure will be followed in respect of verification of wage particulars in the circumstances stated against each:-

- (a) In cases where the accident occurred before commencement of the first benefit period for the insured person, ESIC-32 furnished by the employer in original should be forwarded along with the following certificate recorded under Manager's signature:-

“Wage record of this insured person as shown by employer has been personally verified by me.”

- (b) In cases where the accident occurs after the commencement of the first benefit period for the insured person, and the return of contributions has been received in the Branch Office from the Regional Office, an extract of the return attested by Branch Manager alongwith the certificate of verification of the rate;
- (c) In cases where the return of contributions is not available in the Branch Office, a certificate of verification of particulars given in ESIC-71/ESIC-32 signed by the investigating official and countersigned by the Branch Manager where he himself has not verified the particulars will suffice for the purpose of pre-audit of rate of permanent disablement benefit and of commuted value.

P.5.14. In cases where the factory/establishment has closed down or where the relevant wage records are not available with the employer and resultantly neither the return of contributions has been received in the Branch Office nor wage particulars can be verified from the employer's records, the Branch Manager should address a demi-official letter to the Regional Director separately for each such case, wherein he should indicate the last available rate as per records of the Branch Office. He should also furnish a certificate that the relevant wage records are not available with the employer. In such cases, the rate will be determined by the Regional Office in consultation with the Dy. Director (Finance) on the basis

of previous records or return of contributions for the previous period pertaining to the insured person. PDB rate calculated in this manner will need the approval of Hqrs. Office as detailed in para P.3.15 and P.3.17.

Age proof

P.5.15. As regards item (k) of para P.5.9, the moment it is decided to refer a case to Medical Board, it should be ascertained from register in form ESIC-26 as well as by interrogating the insured person whether his age proof has already been accepted or his age has already been determined by the Medical Board at the time of assessment of any earlier employment injury. If so, this fact should be clearly mentioned in the forwarding letter quoting the earlier reference of Regional Office. In other cases, the insured person may be asked to produce proof of age by issue of a letter in the form at Annexure II, for an immediate compliance/reply by him in Annexure III. To avoid delay, the letter should be handed to him while he is personally present in Branch Office and, in case he says he has no age-proof with him, his reply should be obtained on the spot after deleting the columns not relevant in his case in form at Annexure III.

Location of injury

P.5.16. A thorough check of ESIC-26 register as well as interrogation of the insured person is necessary from another equally important angle: to prevent award of permanent disablement benefit for an earlier injury at or near or about the spot for which the present reference is being made and for which the assessment has already been made and permanent disablement benefit is being paid or has been paid as commuted value. A study of the IMO's answers to the various columns in B.I.1(a) and specially the column "Is there any coexisting condition (e. g., any old congenital or acquired deformity or disease of the injured part) will be immensely helpful in this context. Such a study also helps in preventing an award for an injury sustained by the insured person before he joined employment as an 'employee' under the Act.

P.5.17. As soon as the papers are ready, it should be ascertained through a check of these papers that the descriptions of injury in form 12, ESIC-25, B.I.1, B.I.1 (a), certificates etc., point to the same location in every document.

Despatch of papers

P.5.18.1. The papers in respect of each case should be forwarded to the Regional Office, complete in all respects, under a registered forwarding letter within the following time limits:

- A. Cases which have been already investigated and wage verification where necessary has been conducted before being admitted as employment injury and cases admitted without investigation: within 7 days of the date of termination of temporary disablement or date of receipt of request for reference, whichever happens earlier.
- B. Other cases, e.g., where wage verification/investigation is called for: within 14 days of the above dates.

The Branch Office will also enter further particulars of the case in ESIC-61 register at the time of reference to Regional Office. It will also make a note in the remarks column of the ledger sheet "Referred for Medical Board on" after the remarks "Temporary disablement terminated".

P.5.18.2. Each forwarding letter mentioned in the previous paragraphs will also invariably contain a certificate in the following form :-

- (i) Certified that the insured person has not sustained employment injury other than the employment injury in respect of which papers are being forwarded herewith.
- (ii) Certified that the insured person is not eligible to receive permanent disablement benefit in any other case of employment injury except the one referred to in (i) above and that no

other percentage of loss of earning capacity has been awarded to this beneficiary by Medical Board/MAT/EI Court/High Court.

(iii) Certified that (any other remark).

P.5.18.3. In case the insured person is actually in receipt of periodical payments of permanent disablement benefit in respect of some other employment injury, full details thereof may be indicated in (iii) above after deleting (i) and (ii) above. When the case is received at Regional Office, it should take care to link up previous papers of the earlier employment injury, if any, before referring the case to Medical Board.

P.5.18.4. In case of injury on the part for which assessment of loss of earning capacity was also previously made by a Medical Board, complete history of the case, inclusive of whether IP received commuted value, should be provided and the Medical Board be requested to give a clear decision as to whether the percentage loss of earning capacity for the case being referred now will have to be inclusive or exclusive of the percentage loss of earning capacity awarded previously.

Delayed request for reference to Medical Board

P.5.19. There may be cases where no recommendation for reference to Medical Board was received either from IMO or from Medical Referee nor a request to this effect was initially received from or on behalf of the insured person at the juncture when temporary disablement was terminated but the same is received on a later date. In such cases, the opinion of Medical Referee should be obtained whether this is a fit case for reference to the Medical Board. Since Regulation 72 permits reference to Medical Board if an insured person makes a claim for permanent disablement benefit within 12 months from the date of termination of his temporary disablement benefit or in case no temporary disablement benefit was claimed, from the date of employment injury, such cases will also be referred to Regional Office as usual. However, if such a claim is received after the expiry of the 12 month-period, a letter explaining the reasons for delay in requesting for Medical Board reference may be obtained from the insured person and enclosed with the forwarding letter to the Regional Office. The Branch Office will provide the following information to the Regional Office in the forwarding letter, to enable it to come to a decision on relaxation :-

- (1) Whether the insured person was referred to the Medical Referee during temporary disablement and, if so, whether Medical Referee had indicated that the case is likely to turn into permanent disablement.
- (2) Whether the IMO while issuing final certificate recommended reference of the case to Medical Board.
- (3) Whether the insured person was interrogated by the Branch Manager at the time of final payment of temporary disablement benefit to ascertain whether reference to Medical Board was indicated.
- (4) Whether there is any history of non-employment oriented incapacity after the date of termination of temporary disablement benefit upto the date of examination by Medical Referee. If so, details thereof may be furnished.

The Regional Office will process the case further for obtaining relaxation of the Regional Director who has been given full powers of relaxation.

Advance payment of benefit

P.5.20. Despite stringent measures taken at all levels to expedite award of permanent disablement benefit to insured persons sustaining a permanent loss of earning capacity and despite earnest efforts made by the Branch Office and the Regional Office in this regard, unavoidable delay sometimes occurs causing undue hardship to insured person and specially those who may have suffered a major disability where the loss of

earning capacity is over 25 per cent or more. While considering the means of reducing hardship to these insured persons, the first ESIC Review Committee had recommended that in cases where the estimated

permanent disablement was more than 25 per cent, advance payment of the benefit may be made and adjusted later on when the decision of the Medical Board becomes available.

P.5.21. The Corporation having accepted this recommendation, Director General has relaxed Regulation 76-A in such cases so as to facilitate advance payment @ 75 per cent of the estimated daily rate of permanent disablement benefit to those insured persons who sustain any of those injuries listed in the Second Schedule to the Act, each of which results in over 25 per cent loss of earning capacity.

P.5.22. A list of items mentioned in the foregoing paragraph rearranged location-wise alphabetically may be seen at Annexure IV. As soon as an insured person on temporary disablement submits a final certificate and also brings in his B.I.1. (a), the same should be examined carefully and the insured person interviewed by the Branch Manager so as to ascertain whether the location of his residual disability conforms to any of those listed in Annexure IV. The Branch Manager, being the best judge of the situation and circumstances prevailing at the moment, has to anticipate the delay in examination of the insured person by the Medical Board.

P.5.23. If the residual disability is found in his estimate to be over 25 per cent and if he anticipates delay in examination of insured person by the Medical Board, he should cause an immediate reference of the insured person made to Medical Referee for his report/opinion on the following specific points:

- (1) Whether the residual injury is a scheduled injury.
- (2) Whether loss of earning capacity can be determined finally by the Medical Board.
- (3) Location and description of permanent disability.
- (4) What is the estimated percentage of loss of earning capacity.

The letter to the Medical Referee seeking the above information should have as its enclosures all the relevant papers such as B.I.1(a) etc. and should give complete history of the case, such as duration of temporary disablement, incapacity references made, if any, during the period. An insured person referred to Medical Referee under this paragraph is entitled to the payment of compensation for loss of wages and/or conveyance charges on the same scale as is applicable for cases referred to Medical Board. A form ESIC-142 may be provided to insured person for this purpose.

P.5.24. If the Medical Referee specifically certifies that (i) the injury is a scheduled one and (ii) the anticipated loss of earning capacity would not be less than 25% for that specified injury, the Branch Office will make a reference to the Regional Office for sanction of, as well as daily rate of, advance payment of permanent disablement benefit.

P.5.25. Where the injury is certified by the Medical Referee to be a mixture of both scheduled injury as stated above and a non-scheduled injury, advance payment will be authorised by the Regional Office only with reference to the scheduled part of the injury.

P.5.26. The advance payments of permanent disablement benefit cannot be considered for payment of the commuted value of PDB in lump sum.

P.5.27. The Regional Office, on receipt of papers from Branch Office alongwith Medical Referee's recommendation, will scrutinise the papers and, if the same are found in order, it will propose a rate 75% of the daily rate of permanent disablement benefit based on the loss of earning capacity as estimated by the Medical Referee. It will then send papers to Finance Branch of Regional Office for pre-audit. On receipt of Finance concurrence it will seek Regional Director's approval whereafter it will

convey the same to the Branch Office. However, in the meantime, action to refer the case expeditiously to the Medical Board will continue to be pursued at all levels.

P.5.28. On receipt of Regional Office decision in the Branch Office, entries of advance payment of PDB should be made in the PDB Register as usual. In the remarks column, however, the words "Advance Payment" may be indicated. The total advance payment is to be adjusted against the PDB that may become admissible on the basis of Medical Board decision when available.

P.5.29. It is possible that the daily rate of an advance payment may turn out to be more than the daily rate of permanent disablement benefit that may become admissible on the basis of the assessment made by the Medical Board. A written undertaking should be taken by the Branch Manager from the insured person at the time of forwarding papers to the Medical Referee/Regional Office so as to permit adjustment of excess payment, if any, against the benefit due/admissible in terms of subsequent final assessment by the Medical Board.

P.5.30. In certain cases where advance payment has been authorised, the insured person may not appear before the Medical Board. There may be two such contingencies, viz.,

- (i) where the insured person dies before a date is fixed for examination by the Medical Board and
- (ii) where the insured person dies or is otherwise not available for examination by the Medical Board or on after the date fixed for examination.

In such cases the advance payment of permanent disablement benefit should be restricted till the date of death or the date fixed for the examination by the Medical Board, whichever is earlier. However if, upon an application by the insured person or otherwise the Regional Director is satisfied about the genuine reasons for failure of the insured person to appear before the Medical Board, the advance payment of permanent disablement benefit from the date fixed for examination by the Medical Board till the date of the next Medical Board may be authorised by the Regional Director.

P.5.31. Cases of advance payment of permanent disablement benefit will fall broadly under the following categories :-

- (i) Where the advance payment of permanent disablement benefit has been made at a rate higher than that resulting from the assessment made by the Medical Board; or
- (ii) where the advance payment of benefit is at a rate lower than the one assessed by the Medical Board; or
- (iii) where the insured person dies or is not available for examination by the Medical Board on or after the date fixed for examination.

In cases of category (i) above, the recovery will be made by adjustment against future payments of permanent disablement benefit on the basis of undertaking given by the insured person.

In cases of category (ii) above, the difference of lower rate and higher rate of permanent disablement benefit will be paid to the insured person while making further payments of permanent disablement benefit on the basis of Medical Board assessment.

In case of category (iii) above, the advance payment of permanent disablement benefit will stand automatically regularised since the Corporation has already adopted the procedure of advance payment of permanent disablement benefit on the basis of Medical Referee's assessment. Such cases where the insured person dies or is otherwise not available for assessment of loss of earning capacity by Medical Board and advance payment of permanent disablement benefit has already been made, need not be referred to headquarters for regularisation.

Reference to Medical Board by Regional Office

P.5.32. When papers for reference of a case to Medical Board are received in the benefit branch of Regional Office, the case will be entered in the Regional Office register in Form ESIC-151. The papers will then be thoroughly checked and, in case any information is lacking, the same will be obtained from the Branch Office without delay. The Regional Office on receipt of papers from the Branch Office shall process the case papers within a period of not more than 7 days and refer the case to the Medical Board.

P.5.33. In order to avoid (i) delay in disposal of cases and (ii) accumulation of cases, the Regional Office should ensure that meetings of the Medical Board (s) are conducted regularly. The best thing would be a standing arrangement whereby the Medical Board meets regularly every month to examine all cases received since the last meeting. A meeting may be held even if there is a single case to be seen; the tendency to postpone the meeting until there is an accumulation of cases should be resisted. In case the Medical Board does not meet for some time due to one reason or other, or in case of heavy accumulation or otherwise, Regional Office should avail of the services of peripatetic Medical Board constituted by the Headquarters Office or of the Medical Board of a neighbouring area.

P.5.34. When the date, time and place have been fixed for the Medical Board meeting, the same will be communicated by ordinary post without certificate of posting to the insured persons concerned in form ESIC-134 at least a week before the date fixed for Medical Board meeting, requiring him to appear before the Medical Board, under intimation to the employer and the IMO/IMP of such insured person with a request to communicate the information to the insured person concerned. Where the insured person fails to attend the Medical Board meeting and he is referred for a second time, such intimation should be sent under Registered A. D. cover with a copy to Branch Office, the employer/IMO or IMP by ordinary post with a request that insured person concerned may be advised to attend the Medical Board meeting. In case a request for reference to the Medical Board is made by any employees' trade union, they may also be informed about the date, time and place fixed for the examination.

P.5.35. The papers for the Medical Board should, where necessary, be got scrutinised by the Medical Referee. In all clear-cut cases, however, where the Regional Director is satisfied that necessary Medical Board documents and all relevant information in regard to the disability are complete in all respects, prior reference to the Medical Referee may be dispensed with. Further, where, in a particular case, the opinion of the Medical Referee is available, the same should invariably be sent to the Medical Board alongwith other papers connected with the case. The assessment of the Medical Referee obtained for the purpose of advance payment of PDB should also be brought to the notice of the Medical Board at the time the case is referred for assessment. The papers, complete in all respects including B.I.2 in duplicate with its first part duly completed, should be despatched by Regional Office so as to reach the Chairman of the Board at least 3 days prior to the date of the meeting. If age of the IP has to be determined, this part will also contain a request for the same at the end just above the signature column, thus: "Medical Board is also requested to estimate the IP's age and record it against S.No. 8 of Part III". Two copies each of blank forms BI.3 and BI.4 will also be attached.

P.5.36. Before referring a case for Medical Board examination, the Regional Office has to make sure that the insured person has not sustained an earlier employment injury on the same location as now reported. This information would be available from the papers forwarded by the Branch Office, B.I.1(a), as also from the records maintained at the Regional Office. In case it is found that the insured person had sustained an employment injury earlier on the same location, full facts of the case clearly indicating the nature and extent of the injury and the percentage of loss of earning capacity awarded earlier may be explained for the guidance of the Medical Board in coming to the correct decision in respect of the present employment injury. In a case like this, the age of the IP would have been already determined and will be on record and, therefore, no fresh estimate of age would be required.

P.5.37. The insured person will appear before the Medical Board on the date, time and place fixed as intimated to him by the Regional Office. The Medical Board will examine him to determine (a) whether the relevant accident has resulted in permanent disablement, (b) whether the extent of loss of earning

capacity can be assessed provisionally or finally, and (c), in case of provisional assessment, as to the period for which such assessment shall hold good. They will then complete Part II and Part III of B.I.2. The Board will also complete B.I.3 and, if necessary, B.I.4 giving their decision. The original copy of B.I.2 and B.I.3 and, where necessary, B.I.4 will also be sent to the Regional Office. When so required, they will also assess the age of the insured person and record the same in their report.

Regional/Branch Office official to assist Medical Board

P.5.38.1. In order that report of the Medical Board is available without delay, the Regional/Branch Office will depute one of its officials to assist the Medical Board. He will assist the Medical Board in every way in general with a view to ensuring correct and complete disposal of every case examined by them; he should in particular –

- (i) assist in recording the claimant's statement in part II of B.I.2 report;
- (ii) get papers and reports completed in all respects on the spot;
- (iii) ensure that every form has been signed by each Member with date and that every correction is duly attested with full signatures of Chairman;
- (iv) see that in cases where age is to be assessed, the same is entered by the Chairman both in figures and in words over his dated signature in the B.I.2.
- (v) make payment of conveyance charges and/or loss of wages on the spot after getting relevant columns in form ESIC-142 meant for Chairman, Medical Board, filled in on the spot and duly signed by him.

P.5.38.2. As regards (i) above, ESIC Medical Manual lays down that in recording the narrative of subjective symptoms in part II of the report form, the claimant's own unprompted language should be quoted by the Medical Board (in quotation marks) as far as possible. If, after clinical examination, the Medical Board considers that the subjective symptoms are unrelated to the inquiry at issue, the fact should be stated in the report.

P.5.38.3. The official will also bring back all the papers personally so as to avoid delay in their despatch to Regional Office.

Rectification of errors by Medical Board

P.5.39. In case any clarification is still found necessary on the opinion expressed by the Medical Board in their report, the same may be referred to the Chairman of the Medical Board with full particulars. Where Medical Board or its chairman does not consider it necessary to examine the insured person again before reply to the clarification sought is given, the Chairman may be requested to record in writing the circumstances/reasons as to why it is not considered necessary to examine the insured person. An obvious discrepancy or clerical error is to be rectified by the Chairman in writing under his signature on the appropriate form (B.I.2 or B.I.3) itself – a mere verbal clarification from the Chairman will not meet the requirement. If the assessment of the Board is considered wrong or excessive, the proper course is to appeal against it, instead of requesting the Medical Board or its Chairman to review or revise their decision.

P.5.40. In view of difficulties experienced by Regional Directors in getting minor omissions/errors in Medical Board form B.I.2 and B.I.3 corrected by Chairman after the examination, it has been decided that clerical mistakes relating to incorrect insurance number, name and date of Medical Board examination may be corrected by Regional Director/Deputy Regional Director over his dated signatures.

Provisional assessment

P.5.41. All cases where the period of provisional assessment has been specifically stated in the recommendation of the Medical Board should be referred to the Medical Board for review not later than the end of the period taken into account by the provisional assessment. Every effort should be made to initiate a reference to Medical Board for the review as close to the end of provisional period as possible. The things should, however, be so arranged that while the case may be referred to the Medical Board a little before the expiry of the provisional assessment, the insured person should be examined only after the expiry of the provisional assessment. The revised rate of permanent disablement benefit consequent on this review shall be operative from the date on which the Medical Board reviews the assessment or the date following the date upto which the previous assessment holds good, whichever is earlier. Please also see in this connection para P.5.45 below.

Action on receipt of decision

P.5.42. Medical Board's decision when received in the Regional Office will be found to fall in one or other of the following categories of disablement :-

- (i) 'Final'
- (ii) 'Provisional' with period stated
- (iii) 'Temporary'

P.5.43. In some cases of 'final' assessment the Medical Board decision may read: "There is no appreciable disablement" in which case they would have also indicated zero per cent loss of earning capacity. In such cases, after necessary entries in the register of references to Medical Board, the Benefit Branch of Regional Office will inform the insured person accordingly in form ESIC-154 crossing out columns not relevant and enclose a signed copy of B.I.3. The Regional Office will also send copies of this intimation alongwith attested copies of B.I.3 to the IMO, Branch Manager and the particular employer or employees' union who had originally sponsored the IP's case for reference to the Medical Board. The Branch Manager will make entries accordingly in ESIC-61 register and treat the case as closed.

P.5.44.1. In other cases of 'final' assessment wherein some percentage higher than zero has been awarded, the Benefit Branch will scrutinise the same with reference to the location, nature and extent of the present injury and the nature and extent of an old injury, if any, at the same location, keeping in view the relevant percentages given in the Second Schedule and if it considers reasonable, calculate the daily rate of permanent disablement benefit. Fractions of paise will be retained and shall not be rounded off. The Benefit Branch will refer the case alongwith complete papers received from the Branch Office and from the Medical Board to the Finance Branch for pre-audit of the rate as well as eligibility to benefit. On receipt of concurrence from Finance Branch, the Benefit Branch will submit the case papers for approval of rate as well as acceptance of the insured person's age by Dy. Director/Assistant Director incharge of Benefit Branch or, in his absence, by the Regional Director. Thereafter, necessary entries will be made in the Regional Office register in form ESIC-151. Letters/intimations will be prepared and despatched to various concerned parties in the same manner as in the case of 'zero' assessment. However, Regional Office will ensure to send intimation meant for the insured person by registered A. D. post in those cases where he is found entitled to commuted value.

P.5.44.2 The Benefit Branch in the Regional Office should not take more than seven days for processing the case after the receipt of B.I.3 from the Medical Board and sending it to the Finance Division for concurrence of rates etc. The Finance Division of the Regional Office should accord the concurrence within a period of seven days. On receipt of the file from the Finance Division, the Benefit Branch of the Regional Office should issue the decision in form ESIC-154 immediately and in any case not later than 3 days.

P.5.44.3 If Regional Office considers that the decision of the Medical Board is not acceptable, it should promptly file an appeal.

P.5.45. In case of provisional assessment also, the procedure as outlined in the foregoing para will be followed at Regional Office as well as at Branch Office and a second reference of the case to the Medical Board will need to be carefully watched both by the Regional Office and the Branch Office in the manner stated in para P.5.41.

When Medical Board declares disablement as ‘temporary’

P.5.46. In some cases, the Medical Board may have opined that the disablement should continue to be treated as ‘temporary’. In such cases, they would have also indicated the next date of reference to them but they may or may not have filled in form B.I.4 indicating the line of treatment for the insured person. The other possibility is that they might also have already given form B.I.4 to the insured person. In all these eventualities, Regional Office will inform all concerned as well as the insured person about the Medical Board’s opinion and will direct the insured person to approach his IMO who would provide him treatment and would also decide the question of issue of medical certificates to the insured person in consultation with Medical Referee. The IMO will also give clear indication of the Medical Board’s recommendation in the remarks column. The Branch Manager will resume payment of temporary disablement benefit treating this as a relapse case but he will take care to refer the case again to Medical Board immediately after the period of treatment as indicated by the Medical Board is over or on date, if any, stated by the Medical Board in B.I.4 on which Medical Board has directed the insured person to appear before them, as the case may be. If certification continues even after the date fixed for examination by the Medical Board or after the period indicated by them, payment of temporary disablement benefit for the days will be made only in case the Medical Board on a fresh examination again declares the disablement to be temporary. Otherwise, if the Medical Board declares the disablement to be of a permanent nature and awards a percentage, only permanent disablement benefit will be admissible from the date of examination by the Medical Board. However, sickness benefit, if admissible, will also be payable for the period in question in addition to permanent disablement benefit.

Action at Branch Office

P.5.47. Every decision/intimation received from Regional Office in respect of cases referred for Medical Board examination will be entered in the Branch Office register of Medical Board references in form ESIC-61. The entries will be made by the claims clerk and attested by the Manager. In respect of cases whose provisional or final loss of earning capacity has been awarded and the Regional Office has intimated its acceptance and conveyed the daily rate of benefit, the claims clerk will enter each such case in the index of permanent disablement benefit register and allot 2 sheets next after the case last entered, fill in all the columns in the first of the allotted pages, initial the entries and submit the register alongwith the documents to the checker who, after checking the entries and initialling them, pass it on to the Manager for checking and attestation of the entries. The daily rate of benefit will be entered both in figures and in words and the Manager will append his full signature below this rate. Permanent disablement benefit and dependant’s benefit are recurring payments just like pension. It is the responsibility of the Manager, being the disbursing officer, to see that the rate of benefit etc., as entered in the ESIC-26 and ESIC-40 registers, is the correct one and has been duly attested by him or by his predecessor in office. If the award is provisional, the date of termination will be calculated by adding the period for which it is valid with reference to the date of examination and written under the column “Date of Review”. The words “Provisional (date of review/termination)” will be added on top of the page in red ink and underlined so as to avoid the possibility of payment beyond this date. A new entry may also be made simultaneously in ESIC-61 register after the last entry so as to watch timely reference of the case to the Medical Board.

Payment when Medical Board decision not accepted by RO

P.5.48.1. In cases where Medical Board decision is not accepted by the Regional Office, it will clearly state in the letter (ESIC-154) addressed to the insured person, copy to the Branch Manager, that the decision is not acceptable to the Corporation and that an appeal has been/is being filed against the decision.

P.5.48.2. Regional Director will ensure in every such case of appeal that application for stay of payment is also made simultaneously and efforts are made to obtain the stay order. If the Appellate Court grants stay against decision of the Medical Board/M. A. T., no payment of PDB is to be made.

P.5.48.3. In case stay is not granted by the Court, the Regional Office will additionally advise the IP to claim and receive PDB at the rate based on loss of earning capacity as determined by the Medical Board.

P.5.48.4. When the IP visits Branch Office to claim PDB, an undertaking may be obtained from him that in case the decision of the appellate Court goes against him, the amount of PDB paid in excess shall be refunded by him.

P.5.48.5. On receipt of decision on appeal, if E. I. Court lowers the percentage loss of earning capacity than what was determined by the Medical Board/M. A. T., excess payment of PDB made to the IP will have to be recovered from him. This may be done by adjustment from future payments subject to written consent obtained from the IP.

Intimation to insured person

P.5.49.1. The Branch Office will issue intimation to the insured person immediately on receipt of Regional Office communication awarding daily rate of permanent disablement benefit, and in any case within 3 days of the receipt of these papers. In case the insured person does not contact the Branch Office, the BM should himself contact the insured person through the employer or by sending a letter to the latest address of the insured person available with the Branch Office advising him to submit the claim alongwith the life certificate etc. Ultimately it has to be ensured that the insured person receives his first payment of permanent disablement benefit within two months after the temporary disablement is over.

Action on first claim

P.5.49.2. When the insured person calls at the Branch Office, the claims clerk will check all the papers and obtain his claim on Form 25 (renumbered as form 14 w.e.f. 1.1.05), make entries in the claims diary as well as in the ESIC-26 register and take him to the Manager who will (i) obtain the insured person's specimen signature and (ii) record his identification marks on top right hand corner of the relevant page of the register under his attestation. The claims clerk will then prepare his claim and make entries thereof in the relevant columns of ESIC-26. The claim after being checked by the checker will be passed on to Manager for pay order and therefrom to the Cashier for payment.

P.5.49.3. First payment of permanent disablement benefit should invariably be made at the Branch Office in the presence of the Branch Manager, for the period from the first due date to the last date in the month preceding one in which payment is made and subsequent payments, except the last, will be for complete calendar months

Transfer to more convenient Branch Office

P.5.50. At the time of first payment of permanent disablement benefit the Branch Manager should personally check up whether it would be more convenient for the claimant to receive future payments at any other Branch Office of the Corporation and, in that case, after obtaining the claimant's written request for change of Branch Office, he should send necessary records to the new Branch Office under advice to Regional Office. Where, however, the Branch Office opted by the claimant falls within a different region, the necessary papers should be routed through the parent Regional Office. In either case, care should be taken that the flow of the periodical payments is not interrupted due to the transfer of the case. In cases where transfer of records is necessary, certified copies of the following documents should be sent:-

- (1) ESIC-26
- (2) Regional Office decision awarding the benefit.
- (3) Other correspondence having a bearing on the case.

Subsequent (monthly) payments

P.5.51. The insured person may be advised to claim all subsequent payments through money-order, unless otherwise necessary and Branch Office may also send letter to him in form ESIC-156 (specimen at Annexure V) alongwith the claim form (form-25) and form of life certificate (form 26) if necessary, in the third week of every month requesting that the insured person may claim benefit by submitting/sending the forms duly completed. Special care should be taken to see that periodical payments are regularly made through money-order, if so required by the insured person.

ECS facility for monthly payments of PDB

P.5.51A In order to ensure hassle free and timely delivery of PDB month after month, the system of payment of this benefit through the electronic clearance system (ECS) has been approved by the Director General. The following procedure will be followed in this regard:

(1) Insured persons entitled to receive PDB may be given an option to receive the monthly payments through ESC.

(2) Those who opt for this system have to submit details of their bank account, such as name of the bank, branch name, account no., MICR no. Etc.

(3) Those of the optees who do not have a bank account will be whole heartedly and vigorously assisted by the ESIC Branch Manager in getting their accounts opened with either the SBI or any other nationalized bank.

(4) Money shall be transferred to the Bank Accounts of the beneficiaries through ECS in case of other banks and CBS in case of SBI and the cost of remittance will be borne by ESIC. The beneficiaries will be informed through communication through sms or by phone or other modes about the transfer to their accounts.

Six monthly life certificate - claim

P.5.52.(i) Every claimant for permanent disablement benefit is required to submit a declaration and certificate in form-23 to be granted by the authority specified in para L.5.51 with the claims for the months of June and December. A blank form 23 should be sent to the person entitled to the benefit along with ESIC -156 in the third week of June and December every year. Notwithstanding the production of such a declaration and certificate, a claimant other than a person incapacitated by bodily illness or infirmity or a pardanashin lady, may be required to present himself/herself in person at the Branch Office but not more frequently than once in 6 months. This, however, should be enforced very sparingly, Pleas also see para P.5.75 in this regard.

P.5.52 (ii) All PDB recipients including those receiving payments through ECS facility will henceforth submit claims during June and December for the next 6 months together alongwith a life certificate to the Branch Offices and the Branch Office will go on remitting PDB to their bank accounts of those having their bank accounts through the ECS facility as well as to the postal address of those who are unable to get their accounts opened with the bank.

Commutation

P.5.53. It will be advisable that before going through the procedure for commutation given in these paragraphs, the provisions in the Act (Section 54A) and in the Regulations and clarifications thereunder as given in paragraphs L.5.37 to L.5.41 are gone through carefully. Daily rate of permanent disablement benefit can be commuted into a lump-sum payment –

(i) if the permanent disablement has been declared 'final', and

(ii) (a) If the daily rate of benefit does not exceed Rs. 5.00

OR

- (b) if in respect of the final award given by the Medical Board on or after 19.4.2003, the daily PDB rate exceeds Rs. 5.00 but the commuted value with reference to the admitted age of the IP, or his age as determined by the Medical Board, would not exceed Rs. 30,000/-

P.5.54.1. When IP calls at the Branch Office for payment of PDB, his case should be carefully scrutinised to see if his daily rate makes him eligible to receive commuted value. Possibly, he may, on his own, submit an application for commutation on the form received by him from Regional Office. If he does not do so, and he is otherwise found eligible to receive the commuted value, he may be asked to submit his application for commutation in the form at Annexure VI. He can submit his application on plain paper also, but it is important for the Branch Office to ensure that the same language is used as is specified in Annexure VI.

P.5.54.2. IP's application for commutation, on its receipt, should be diarised in the receipt diary of the Branch Office and serial number of the diary and date of its receipt should be indicated on it. If the application is received in the Regional Office, it should be diarised in the receipt diary of Regional Office and diary number and date of receipt indicated clearly on it. This will then be forwarded to the concerned Branch Office without delay. The date of receipt in Regional Office will be deemed as the date of receipt in the concerned Branch Office.

P.5.55. In case the application for commuted value is submitted within 6 months of the date of possible option, and the commutation is possible, the following steps will be taken by the Branch Office :-

- (i) Enter date of receipt in ESIC-26 register as date of stoppage of permanent disablement benefit. In other words, periodical payments of benefit will be admissible only upto the date prior to the date of receipt of the application. "Stop periodical payment with effect from" will be entered in remarks column of ESIC-26 in red ink.
- (ii) Make entries of the claim in the Branch Office register of commutations which should have the following columns:-
 1. Serial number.
 2. Name and Ins. Number.
 3. Page number of register of permanent disablement benefit.
 4. Date of receipt of application in Branch Office/any other office of Corporation.
 5. Date of forwarding of papers to Regional Office.
 6. Date of receipt of decision on commutation from Regional Office.
 7. Date of payment of commuted value.
 8. Remarks.
- (iii) Complete the papers including (a) a reference to the admitted age of the insured person and (b) a mention of whether or not any other claim for PDB or commutation of the same insured person has been admitted or is in process (giving full details thereof), and send them under a forwarding letter to the Regional Office, after making entries in the register of commutations, within 3 days of the receipt of the application for commutation. Delay in submission should be explained. If decision is not received within a month, reminder will be sent, followed by half-monthly reminders with suitable entries in the register. This register will also be

inspected by inspecting officers of Regional Office during their inspection visits to the Branch Office.

P.5.56. If the application for commutation is received after the expiry of six months from the date of possible option (for an explanation of this date, please refer to para L.5.38), the Branch Office will immediately refer the insured person to the Medical Referee for his opinion whether the insured person has average life expectancy as required under sub-regulation (3) of Regulation 76-B. If the Medical Referee confirms that the insured person has in fact average life expectancy, a note to that effect will be recorded under Manager's signature in the ESIC-26 register and the commutation register and the case papers of commutation alongwith communication received from Medical Referee will be referred to the Regional Office in the same manner as outlined in the preceding para.

P.5.57. In some cases, the Medical Referee will state that the insured person does not have average life expectancy. Since commutation is not to be allowed in such cases, the Branch Manager should immediately on receipt of Medical Referee's opinion, call for the ESIC-26 register and the commutation register, get the entries made in red ink in his presence to the effect "Medical Referee opines IP does NOT have average life expectancy *vide* his letter dated Commutation NOT admissible" and append his full signatures below the entry. He should also inform Regional Office accordingly and file the papers in the PDB file of the insured person. He should also resume periodical payments of permanent disablement benefit and advise the insured person to claim these payments if the same have become due. The entry of "Stop payment" already made in the ESIC-26 register will also be cancelled under his signature. It is to be noted that under proviso to sub-reg. (1) of Regulation 76-B, cases where commutation has been refused are not to be re-opened.

P.5.58. In a solitary case, the Medical Referee may find an insured person suffering from some temporary ailment, i. e., a minor ailment of a short duration and may advise Branch Office to refer him again after some time. A watch may be kept over the progress of such a case and the insured person referred back to Medical Referee as soon as he reports recovery from the ailment or claims to be in good health, for opinion whether the insured person has average life expectancy.

P.5.59. Cases referred to Regional Office for commutation will be quickly processed in the Benefit Branch. That branch will calculate the amount of commuted value and send papers for pre-audit of the commuted value to the Finance Branch. On receipt of the file after pre-audit and concurrence, the Benefit Branch will make entries in the relevant register and send intimations to the insured person as also to the Branch Office regarding amount of commuted value payable (expressed in figures and in words).

P.5.60. When insured person calls for receiving the amount of commuted value, he should be asked to produce the original intimation letter received by him from the Regional Office and after his due identification, claim for commuted value obtained in modified form 14 (see annexure VII) and diarised in the claims diary. Another claim for the balance of days elapsing between the date upto which periodical payments have been made and the date on which insured person's application for commuted value was received in an office of the Corporation should be obtained in the original form 14 and entered in the claims diary. The claim papers will be prepared and checked in the same manner as in case of periodical payments of the benefit. In addition, at the time of preparation of the claims, the following entry will be made by means of a rubber stamp in the relevant page of ESIC-26 register, intimation letter from Regional Office to insured person and its copy endorsed to the Branch Office:

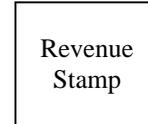
"CANCELLED by way of FINAL Payment of commuted value of Rs (Rupees only) on(date)." The insured person's copy will also be filed alongwith the benefit payment docket. A final discharge in the following form, duly stamped and signed by the insured person, should be obtained from him and pasted on the back of the payment docket:-

Received Rs.....(Rupees.....) from the Branch Manager, Employees' State Insurance Corporation, in cash/by cheque or demand draft No..... dated on account of commuted value of permanent disablement benefit in full and final settlement of claim for

compensation for the employment injury sustained by me on While working with M/s.
..... Code No

Witness signature:

Full signature:



Name:

Name:

Address:

Ins. No.:

Address:

The above discharge would obviate the need for taking a separate acquittance on the payment docket. The payment slip will be handed over to the insured person.

P.5.61. An intimation of the payment should be invariably sent to the Regional Office (Benefit Branch) which will cancel the office copy of intimation letter to the insured person as also the case file by means of a rubber stamp similar to the one for the Branch Office. Entries will also be completed in the Regional Office commutation register.

P.5.62. Apart from procedure for payment of cash benefits as outlined in the relevant paras of the Chapter on General Claims Procedure, the following instructions should be followed in respect of payments of commuted value:

- (i) Commuted value should not be remitted by money order even when the insured person has already visited the Branch Office for receiving the first payment of permanent disablement benefit in person. However, if an insured person from an outstation desires that commuted value may be remitted to him, there is no objection if the same is sent by crossed demand draft. Alternatively, the insured person may be advised to claim it in person from the Manager of the Branch Office nearest to him.
- (ii) If the commuted value does not exceed Rs. 1000/-, it may be paid either in cash or by cheque/demand draft at the option of the insured person. But if it exceeds Rs. 1,000/-, it will be paid only by crossed cheque/demand draft.
- (iii) Charges for the demand draft will be borne by the Corporation.
- (iv) The amount of commuted value when paid in cash should be paid by the Cashier in the presence of the Branch Manager who will record on the payment docket a certificate to the effect "Paid in my presence to Shri, Ins. No..... who has been identified by me."
- (v) Commuted value should be paid to the insured person immediately after authorisation/intimation is received from the Regional Office and there is no justification in withholding the payment until after the period of limitation for appeal, i. e., 3 months, is over.
- (vi) Delay in payment beyond one month from the date, form 14 was submitted by the insured person is to be reported to Regional Office as per provisions of Regulation 52(3). This may be included in statement under Regulation 52 submitted every month to Regional Office.
- (vii) At the time of completing the claim papers for payment of commuted value, it will be ensured that no periodical payment of permanent disablement benefit has been made for the days from the 'stop' date onwards. In case any such payment has in fact been made, it has to be deemed as overpayment to be recovered from the commuted value by adjustment after obtaining the insured person's written consent thereto.

Incapacity beyond Medical Board decision

P.5.63. In cases where the Medical Board has decided that the disablement of the insured person is of a permanent nature and has accordingly assessed the extent of loss of earning capacity, the decision of the Medical Board if accepted at Regional Office will be followed. If the IMO/IMP continues to issue a certificate after the Medical Board decision, the incapacity from the date of examination by the Medical Board should be treated as a fresh spell of sickness for which sickness benefit, if due and admissible, may be paid and, where required under the law, after deduction of 2 waiting days. However, permanent disablement benefit, if admissible, will also be payable for the period of incapacity treated as spell of sickness.

Date from which payable

P.5.64. For a discussion on the above heading, please refer to paragraphs L.5.27 to L.5.29 of the Chapter on PDB Law. Certain important decisions/instructions in this regard are stated below:-

- (a) Where, pending reference to and/or examination by Medical Board, a relapse of the employment injury occurs to an insured person, payment of permanent disablement benefit shall commence from the date of termination of the first spell of incapacity which follows immediately after the employment injury. During the second and subsequent spells of temporary disablement, the insured person will be entitled for temporary disablement benefit and permanent disablement benefit will remain suspended during the period.
- (b) Where, after examination by the Medical Board and final assessment of loss of earning capacity by it, a relapse of the employment injury occurs, sickness benefit will ordinarily be payable, if due, for the period of incapacity in addition to the permanent disablement benefit. If, however, on an appeal or otherwise, temporary disablement benefit is held to be payable for the said period, temporary disablement benefit alone will be paid and permanent disablement benefit will remain suspended.
- (c) In cases of the type mentioned in (b) above, where the insured person has already received commuted value of permanent disablement benefit in respect of the said injury, temporary disablement benefit will not be admissible for the period of relapse. However, sickness benefit may be paid, if found due and admissible.

Injury on a pre-existing injury site

P.5.65. If an insured person sustains employment injury on a limb or member of limb, etc. while in receipt of permanent disablement benefit for loss of earning capacity due to a previous employment injury sustained on the same site, he will be entitled to temporary disablement benefit, if otherwise eligible, in addition to permanent disablement benefit already in force.

P.5.66. As for admissibility to permanent disablement benefit for a second injury on the same site, if the permanent disablement benefit awarded earlier for the same site is the maximum awardable under the Second Schedule, the insured person will not be entitled for any further permanent disablement benefit due to the second injury on the same site. This is because he is already in receipt of the maximum permanent disablement benefit for loss of the limb or member of the limb, etc., as the case may be, admissible under the Act.

Medical care during relapse

P.5.67. Under proviso to Regulation 103, an insured person who is in receipt of permanent disablement benefit for a certain employment injury is also entitled for medical treatment that may become necessary for the said injury even if he is otherwise debarred from medical benefit. If any insured person approaches the Branch Office with a relapse (or aggravation) of the old injury for which he is in receipt of permanent disablement benefit and desires treatment for the same, his present entitlement to medical care

should be checked by interrogating him to see whether he is still covered as an 'employee' under the Act and by verifying his contribution record in the Branch Office. In case he has been debarred from medical care, the Branch Manager should give him a letter addressed to the Insurance Medical Officer (with a copy to the Medical Referee) giving therein full particulars of the employment injury suffered by him for which he is in receipt of periodical payments of permanent disablement benefit and requesting the Insurance Medical Officer to provide him necessary treatment if the former is satisfied that the insured person in fact needs treatment on account of relapse (or aggravation) of the old injury. The IMO should also seek confirmation from Medical Referee about the relapse. Medical certificates may also be issued to the insured person if he needs medical attendance and treatment and abstention from work. (It is immaterial that insured person is no longer covered as an 'employee' under the Act). Payment of temporary disablement benefit for the period of incapacity will be made in lieu of permanent disablement benefit on confirmation by the Medical Referee and authorisation by the Regional Office. In cases where the insured person has received commuted value for an employment injury, medical treatment for the relapse of the said injury will not be admissible unless the insured person is otherwise entitled to medical care.

Death before Medical Board Examination

P.5.68. It sometimes happens that all the papers are ready for reference to the Medical Board or the papers have already been sent to the Medical Board, but the insured person dies before he could appear for examination by the Medical Board. In such cases, a reference may be made to Headquarters for relaxation of Reg. 73 by the Director General whereafter Medical Board may be requested to determine the loss of earning capacity on the basis of case papers alone and permanent disablement benefit upto and including the date of insured person's death can be paid to his nominee or his legal heir.

Appeals

P.5.69. Provisions of the Act and Central Rules on the subject have been stated in paragraphs L.5.19 to L.5.21 and the procedure for setting up of Medical Appeal Tribunals has been spelt out in paragraph L.5.42 to L.5.43 and may be seen in this connection. A period of three months has been provided for preferring an appeal against Medical Board decision. It is to be noted that this period is to be reckoned (i) for the Corporation from date of Medical Board decision and (ii) for the insured person from the date of communication of Medical Board decision by the Regional Office. Since the decision is communicated first to the Regional Office which, in turn, communicates it to the insured person, this period of limitation expires much earlier for the Regional Office than for the insured person and necessary sense of urgency has to be exercised at all levels in case Regional Office decides to go in appeal against Medical Board decision.

P.5.70. An insured person who wants to make an appeal against the decision of the Medical Board, may do so after giving a notice in form B.I.5 within three months from the date of communication of the Medical Board decision to him. If such a notice is received at the Branch Office the same will be duly forwarded to the Regional Office after an appropriate entry in remarks column of the Medical Board register (ESIC-61) and further action will be taken only after a decision is received from the Regional Office. Where the Regional Office decides to file an appeal against the decision of the Medical Board, the Branch Office will be informed of the position and, in that case also, a note is to be kept in the Medical Board register (ESIC-61).

Increases in PDB rate

P.5.71. Paras L.5.24 to Para L.5.25 describe percentage increases allowed from various dates in the past and may be referred to in case of need. These also describe the method of calculation of the enhanced rate to the nearest paisa. However, when arrears of enhanced amount are to be paid, the total amount of arrears being the difference payable between the amount admissible at the old rate and the revised rate should be rounded off to the next higher rupee.

P.5.72. In case where the original rate of permanent disablement benefit was determined after pre-audit the revised daily rate may be calculated at the Branch Office and entered in red ink in both figures and words on the relevant page of ESIC-26 register and attested by the Branch Manager. An intimation about the increase in rate shall be sent to each insured person at his latest address by registered post. The revised rates and amounts will be checked by the internal audit party during its next visit.

Commutation only on increased rate

P.5.73. Where request for commutation is received after the date of effect of enhancement, the revised daily permanent disablement benefit rate should be calculated and commutation allowed at enhanced rate but only if it does not exceed the monetary limit laid down in Regulation 76-B as a result of the enhancement. The commutation cases will require to be pre-audited as usual.

Review Medical Board

P.5.74.1. The provisions of law on the subject as described in Section 55 of the Act have been explained in para L.5.44 & L.5.45 of PDB Law. A review is called for in the circumstances explained therein.

P.5.74.2. Whenever an IP approaches the Branch Office for a review of the decision of the Medical Board/Medical Appeal Tribunal, the Branch Manager will consider his application and such other facts brought before him as may be relevant and, if he finds that review is called for, he may refer the matter to the Regional Office for 'Review' Medical Board.

Personal appearance necessary in certain cases

P.5.75 As per para P.5.52.(ii) *supra* read with Regulation 107-B, the Branch Manager may require personal attendance and identification of a claimant other than a purda nashin lady or one incapacitated by illness or infirmity at his Branch Office, etc., once every six months. This should, however, be resorted to sparingly and judiciously. The Branch Office can, however, justifiably require personal appearance of those persons whose claims for payment by money order together with the six monthly certificates are being regularly received for a long time and who are neither living too far away from the Branch Office nor are they reported to be bodily incapacitated. This is necessary to rule out the possibility of fraudulent claims being submitted by a person other than the claimant himself who might have died and the Branch Office has remained unaware of his death.

Claims remaining unpaid

P.5.76 There may be other cases where a claim for periodical payment of permanent disablement benefit is not received for a considerably long time and communications addressed to the insured person by the Branch Office have remained unacknowledged. The following procedure may be followed in such cases and repeated every five years so as to ensure (i) that payments are received only by the rightful claimants and (ii) that chances of wrong payments to those other than the rightful claimants are eliminated:-

- (i) Where no claim for permanent disablement benefit has been made for a year, a registered special letter may be addressed to the beneficiary asking him to send enclosed claim form duly filled up and to acknowledge the communication within, say, one month.
- (ii) After notice is issued under (i) above, and one-and-half months have elapsed, communication may be addressed to the head of the gram panchayat and the local police station (as far as this can be ascertained) or the Superintendent of the district police requesting them to ascertain the whereabouts of the beneficiary. They may also be requested to send directly a special life certificate for the beneficiary.
- (iii) Where life certificate and whereabouts are not received from the head of the gram panchayat or from the police authorities within three months and inspite of three reminders, a registered

notice may be issued to the beneficiary that no further claim will be entertained from him unless he presents himself personally at the Branch Office for identification, just as he was required to do at the time of first payment of permanent disablement benefit. No claim should be entertained by the Branch Office until he calls in person and has been satisfactorily identified.

Conveyance/Loss of Wages

P.5.77. Detailed procedure for payment of conveyance charges and/or compensation for loss of wages to persons appearing before Medical Referee/Medical Board/Medical Appeal Tribunal has been described in Chapter X1. Certain special features of this subject as are relevant to Medical Boards are stated below and should be read as a supplement thereto:-

- (i) Where the Medical Board, with a view to assessing the permanent disablement of an insured person, directs him to attend a dispensary, diagnostic centre, laboratory or a hospital for purpose of X-Ray or any other diagnostic or specialist examination, conveyance charges and/or compensation for loss of wages may be paid to such insured person at the same scale and subject to the same conditions as are applicable in cases where the insured person appears before the Medical Board itself.
- (ii) Normally, for conveyance charges, the place of residence is the place where the insured person is originally registered. If an insured person subsequently changes his place of residence a statement to this effect should be obtained from him. His new address will then be his "place of residence" for the purpose of conveyance charges and the Medical Board examination should be arranged at the place nearest to the new residence. If, however, an insured person leaves his place of residence after intimation to appear before the Medical Board is sent to him but before he is examined by the Medical Board, his conveyance charges will be restricted to the amount payable with reference to his last intimated place of residence or to the amount claimed with reference to his new residence, whichever is less.
- (iii) Besides compensation for wages lost by the insured person no daily allowance shall be admissible to him even if he has to travel to another town to appear before the Medical Board and has to stay there for more than 24 hours.
- (iv) Where compensation is claimed for loss of wages, a certificate has to be furnished from the employer indicating the number of days for which wages would be lost as a result of appearance by the insured person at the Medical Board meeting and the wages admissible per day.

Branch Office Register of References to Medical Board

Serial No.	Name of insured person	Insurance number	Date of injury	Date of termination of incapacity	At whose initiative referred		Date of reference to Regional Office	No. of days from the date			Decision of the Regional Office					Rate of permanent disablement benefit	Date when insured person asked to collect payment	Date of first payment of permanent disablement benefit	Days taken from the receipt of Regional Office decision to date of payment	Remarks
					IP/employer/Trade Union/IMO/BM	Date of request/recommendation		In column 5 to the date of reference to Regional Office	In column 6B to the date of reference to Regional Office	Date of Medical Board meeting	Date of receipt of decision	No. of days between column 9-10	Whether permanent disability exists	% age of loss of earning capacity	Provisional or final					
1	2	3	4	5	6A	6B	7	8A	8B	9	10	11	12	13	14	15	16A	16B	17	18

I,s./w/d/of Ins. No.

--	--

 having sustained employment injury on (date)
hereby declare that:

1. I possess the following document as proof of my age. This document is enclosed herewith in original –
 - (a) Certified extract from an official record of births showing the date and place of birth and father's name.
 - (b) Original horoscope prepared soon after birth.
 - (c) Matriculation or school leaving certificate or certified extract from school record showing the date of birth and father's name.
 - (d) Certified extract from baptismal register.

OR

2. I cannot produce any proof of age within the time prescribed. As such my age may be got assessed by the Medical Board which will be acceptable to me under Regulation 76-B.

.....
Signature or thumb impression of
the insured person.

Date.....

Address.....

.....

Alphabetical list of disabilities included in the Second Schedule for which advance payment of PDB is admissible

	Description of injury/disability	Serial No. in Second Schedule	Percentage of loss of earning capacity	Remarks
Acromion	Amputation from 20.32 cm. from tip of acromion to less than 11.43 cm. below tip of olecranon.	9	70	
Deafness	Absolute.....	6	100	
Eye	Loss of one without complications, the other being normal (total loss of vision)	31	40	
	Loss of vision of one without complications or disfigurement of eye ball, the other being normal	32	30	
Eyesight	Loss of sight to such an extent as to render the claimant unable to perform any work for which eyesight is essential	4	100	
Face	Very severe facial disfigurement	5	100	
Feet	Amputation of both resulting in end-bearing stumps	17	90	
	Amputation through both proximal to the metatarso-phalangeal joint	18	80	
	Loss of all toes of both through the metatarso-phalangeal joint	19	40	
	Loss of all toes of both proximal to the proximal inter-phalangeal joint	20	30	
Fingers	Loss of four of one hand	13	50	
	Loss of three of one hand	14	30	

	Description of injury/disability	Serial No. in Second Schedule	Percentage of loss of earning capacity	Remarks
	Loss of the thumb and four of one hand or amputation from 11.43 cm. below tip of olecranon	10	60	
Foot	Amputation of one resulting in end-bearing	28	50*	
	Amputation through one proximal to the metatarso-phalangeal joint	29	50*	
	Loss of a hand and a	2	100	
	Amputation through leg or thigh on one side and loss of other	3	100	
Hand	Loss of a	10	60	
	Loss of a and a foot	2	100	
	Loss of both hands or amputation at higher sites	1	100	
	Loss of four fingers of one	13	50	
	Loss of three fingers of one	14	30	
	Loss of the thumb and four fingers of one or amputation from 11.43 cm. below tip of olecranon	10	60	
Hip	Amputation at.....	22	90	
	Amputation below with stump not exceeding 12.70 cm. in length measured from tip of great trochanter	23	80	
	Amputation below with stump exceeding 12.70cm. in length measured from tip of great trochanter but not beyond middle thigh	24	70	

* Raised from 30% to 50% with effect from 20.10.1989

	Description of injury/disability	Serial No. in Second Schedule	Percentage of loss of earning capacity	Remarks
Knee	Amputation below With stump exceeding 8.89 cm. but not exceeding 12.70	26	50	
	Amputation below with stump exceeding 12.70 cm.	27	50.*	
Leg	Double amputation through or thigh, or amputation through or thigh on one side and loss of other foot	3	100	
Shoulder	Amputation through joint	7	90	
	Amputation below .....with stump less than 20.32 cm. from tip of acromion	8	80	
Thigh	Double amputation through leg or or amputation through leg or on one side and loss of other foot	3	100	
	Amputation below middle to 8.89 cm. below knee	25	60	
Thumb	Loss of	11	30	
	Loss of and its metacarpal bone	12	40	
	Loss of the and four fingers of one hand or amputation from 11.43 cm. below tip of olecranon	10	60	
Toes	Loss of all of both feet through the metatarso- phalangeal joint	19	40	
	Loss of all of both feet proximal to the proximal inter-phalangeal joint	20	30	

* Raised from 40% to 50% with effect from 20.10.1989

BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

Dated.....

Shri.....

.....

Ins. No.....

.....

Sub: Your claim for permanent disablement benefit

Dear Sir,

Your claim for permanent disablement benefit for this month becomes due on the first of the next month. Please, therefore, complete the enclosed form 14 on or after the first of the next month and return it to this office promptly thereafter. Please indicate clearly how you want the payment, i. e., by money order at our cost or in person at the Branch Office.

This time you have to produce a life certificate on form 23 which is enclosed. Please have this completed and signed by an officer of the revenue, judicial or magisterial department or a service pensioner of the Government or the head of the gram panchayat of your village or a municipal commissioner or a notary appointed under the Notaries Act, 1952, labour officer or other responsible officer with whom you work or had worked, the president or secretary of a recognised trade union or the Manager of a Branch Office of the ESI Corporation. The official seal or stamp of the signing authority should be affixed to this form which should please be returned alongwith form 14.

Yours faithfully,

Manager

APPLICATION FOR COMMUTATION

To

The Regional Director,

Sir,

I, Ins. No..... of Branch Office hereby apply for commutation of periodical payments of permanent disablement benefit sanctioned to me *vide* your letter in form ESIC-154 dated into a lump sum.

2. I also place on record that I accept the decision of the Medical Board communicated to me in your said letter. I understand that no appeal shall lie under the first proviso to sub-section (2) of Section 54A of the ESI Act, 1948 against the assessment made by the Medical Board if I have applied for commutation of permanent disablement benefit and received the commuted value thereof.

Yours faithfully,

Signature.....

Name.....

Date.....

Full address

.....

CLAIM FOR PERMANENT DISABLEMENT BENEFIT
EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 76-A)

I,s/w/d of.....
Insurance No.

--	--

 having been declared as permanently disabled by the
Medical Board/Medical Appeal Tribunal/Employees' Insurance Court, claim Permanent Disablement
Benefit accordingly for the period from _____ to _____.

The amount due may be paid to me by money order/in cash at Branch Office

Signature or thumb impression
of the Claimant

Name in Block letters _____

and address _____

Dated _____

Important : Any person who make a false statement or representation for the purpose or obtaining benefit whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend up to six months or with a fine up to Rs.2000/-, or with both.

CHAPTER VI
DEPENDANTS' BENEFIT LAW
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CHAPTER VI

DEPENDANTS' BENEFIT LAW

Definition of dependants' benefit

L.6.1. Dependants' benefit consists of periodical payments to such dependants of an insured person who dies as a result of an employment injury sustained as an employee under the ESI Act, as are entitled to compensation under the Act [Clause (d) of Sub-Section (1) of Section 46]. It does not, however, matter whether death occurs instantaneously or after a lapse of some period from the time/date of the accident resulting in the employment injury. For the definition of 'employment injury', reference may be made to Chapters IV & IV A on Temporary Disablement Benefit Law.

There are no contributory conditions for qualifying to this benefit. Thus, if a person dies of employment injury even on the first day of his employment, his dependants are entitled to the benefit.

Definition of dependant

L.6.2. Clause (6A) of Section 2 of the ESI Act says that a "dependant" means any of the relatives of a deceased insured person, namely :-

- (i) *A widow, a minor legitimate or adopted son, an unmarried legitimate or adopted daughter;
- (ia) widowed mother;
- (ii) if wholly dependent on the earnings of the insured person at the time of his death, a legitimate or adopted son or daughter who has attained the age of ** twenty five years and is infirm;
- (iii) if wholly or in part dependent on the earnings of the insured person at the time of his death –
 - (a) a parent other than a widowed mother,
 - (b) a minor illegitimate son, an unmarried illegitimate daughter or a daughter legitimate or adopted or illegitimate, if married and a minor or if widowed and a minor,
 - (c) a minor brother or an unmarried sister or a widowed sister, if a minor,
 - (d) a widowed daughter-in-law,
 - (e) a minor child of a predeceased son,
 - (f) a minor child of predeceased daughter where no parent of the child is alive, or
 - (g) a paternal grand parent if no parent of the insured person is alive.

* w.e.f. 1.6.2010, item (i) above has been changed to read, "A widow, a legitimate or adopted son who has not attained the age of twenty five years, an unmarried legitimate or adopted daughter."

** w.e.f. 1.6.2010

The above definition of "dependant" is somewhat similar to the definition of a "dependant" as given in clause 2 (d) of the Workmen's Compensation Act, 1923, with one important difference that whereas a widower finds no place in the list of dependants as given in the ESI Act, he is included as a dependant vide clause 2(d) (iii) (a) of that Act with a rider "if wholly or in part dependent on the earnings of the workman at the time of his death".

L.6.3. The condition of being dependent on the earnings of the insured person at the time of death does not apply to the relatives named in item (i) viz., a widow, minor legitimate or adopted son, an unmarried legitimate or adopted daughter and item (ia) viz., a widowed mother.

L.6.4. An adopted son or daughter is a dependant under clause (6A) of Section 2. But, to be admitted as such, his/her guardian should submit a declaration as to the adoption being valid from a competent court of law. Mere statement of panchayat or municipality or a Member of Legislative Assembly in support of the adoption should not be accepted by Regional Office as proof of adoption. Conversely, an adoptive parent would also be deemed as a dependant on furnishing proof of adoption, subject to other conditions.

Partial dependence

L.6.5. As per definition of term 'dependant' certain relatives of the deceased insured person become eligible as dependants only if they were wholly or in part dependent on his earnings at the time of his death. To determine whether a relative was partially dependent, court judgments have brought out the following aspects of partial dependence :-

- (i) Dependence is a question of fact and not of law.
- (ii) No yardstick or precise criteria can be laid down on the question and a decision on each case of partial dependence must rest on its own facts.
- (iii) Compensation is not a solatium paid to the relatives of a deceased but something to replace the income loss suffered by them. This test would tend to exclude those parents from the purview of partial dependence whose earning partner makes an income which is much in excess of the deceased's income and/or is sufficient not only to make ends meet but also to maintain a certain reasonable standard of living. Conversely, this test also may help a family whose income in combination with the deceased's income was just or barely sufficient for upkeep of the family.

L.6.6. The conclusion to be drawn from the foregoing is that a relative other than those given in item (i) and item (ia) of the definition has to prove to the satisfaction of the Corporation that he/she was partially or wholly dependent on the deceased's earnings. The mere submission of a claim duly attested by the competent authority is no guarantee to his being admitted by the Corporation as a dependant. The Corporation is also free to admit or reject the claim of a relative of the deceased as a dependant. The Branch Office has to guide and assist the claimants in the matter of submission of claims and to gather relevant evidence in support of dependency where necessary. The Branch Office will also provide its own recommendations in regard to total or partial dependence of a claimant, based on facts and circumstances as seen and verified by it. An illustrative list of such facts and circumstances, which is by no means exhaustive, is given below to help the Branch Office in making its recommendations :-

- (i) Income of parents and other relatives, if any, claiming to be dependant, whether from wages, salary, business, profession and agricultural income, if any.
- (ii) Income of the deceased at the time of his death.
- (iii) Whether the deceased was living with those relatives at the time of his death.
- (iv) Total estimated family expenditure and their style of living.
- (v) Personal expenses of the deceased.
- (vi) Where there is no conclusive evidence that the deceased was contributing to family income, any evidence in support of claim that the deceased was supporting one or more of his relatives individually e. g., his mother, or his younger brother or sister, etc.

Periodical payments

L.6.7. Dependants' benefit consists of periodical payments and no part or whole of this benefit can be commuted into a lumpsum. Each claim must cover one or more complete calendar months except in the case of the first or the last claim where it can be for part of a month also *vide* Regulation 83A of the ESI (General) Regulations, 1950, which is reproduced below :-

83A. Submission of claims for periodical payments of dependants' benefit.- Each dependant whose claim for dependants' benefit is admitted under regulation 82, shall submit to the appropriate Branch Office, by post or otherwise, a claim covering, except in the case of first or a final payment, a period of one or more complete calendar months in form 18A (form 16 w.e.f. 1.1.05). Such claim may be made by the legal representative of a beneficiary or, in the case of a minor, by his guardian.

Entitlement to dependants' benefit

L.6.8. Section 52 of the Act, as amended, states as under :

52. Dependants' benefit.- (1) If an insured person dies as a result of an employment injury sustained as an employee under this Act (whether or not he was in receipt of any periodical payment for temporary disablement in respect of the injury) dependants' benefit shall be payable at such rates and for such period and subject to such conditions as may be prescribed by the Central Government to his dependants specified in sub-clause (i), sub-clause (ia) and sub-clause (ii) of clause (6A) of Section 2.

(2) In case the insured person dies without leaving behind him the dependants as aforesaid, the dependants' benefit shall be paid to the other dependants of the deceased at such rates and for such period and subject to such conditions as may be prescribed by the Central Government.

L.6.8A. The Central Government has made detailed provisions in Rule 58 of the Employees' State Insurance (Central) Rules, 1950, regarding daily rate, duration, eligibility and share of different types of dependants. The said Rule 58 as amended and effective from 1.10.2000 is reproduced below for ready reference.

58. Dependants' benefit.- (1) Dependants' benefit shall be paid to dependants of the insured person who dies as a result of an employment injury, in the following manner :-

(A) In the case of death of the insured person, the dependants' benefit shall be payable to his widow, children and widowed mother as follows :-

(a) to the widow during life or until remarriage, an amount equivalent to three-fifths of the full rate and, if there are two or more widows, the amount payable to the widow as aforesaid shall be divided equally between the widows;

(b) to each legitimate or adopted son, an amount equivalent to two-fifths of the full rate until he attains the age of eighteen years:

Provided that in the case of a legitimate or adopted son who is infirm and who is wholly dependent on the earnings of the insured person at the time of his death, dependants' benefit shall continue to be paid while the infirmity lasts;

(c) to each legitimate or adopted unmarried daughter an amount equivalent to two-fifths of the full rate until she attains the age of eighteen years or until marriage, whichever is earlier;

Provided that in the case of a legitimate or adopted unmarried daughter who is infirm and is wholly dependent on the earnings of the insured person at the time of his death, dependants' benefit shall continue to be paid while the infirmity lasts and she continues to be unmarried;

Provided further that if the total of dependants' benefit distributed among the widow or widows and legitimate or adopted children and widowed mother of the deceased person as aforesaid exceeds at any time the full rate, the share of each of the dependants shall be proportionately reduced, so that the total amount payable to them does not exceed the amount of disablement benefit at the full rate.

(d) to the widowed mother during life an amount equivalent to two-fifths of the full rate

(B) In case the deceased person does not leave a widow or legitimate or adopted child or widowed mother, dependants' benefit shall be payable to other dependants as follows :-

(a) to a parent other than the widowed mother or grand-parent, for life, at an amount equivalent to three-tenths of the full rate and if there are two or more parents other than widowed mother or grand-parents, the amount payable to the parents (other than widowed mother) or grand-parents as aforesaid shall be equally divided between them;

(b) to any other –

(i) male dependant, until he attains the age of eighteen years,

(ii) female dependant, until she attains the age of eighteen years or until marriage, whichever is earlier or if widowed, until she attains eighteen years of age or remarriage, whichever is earlier;

at an amount equivalent to two-tenths of the full rate:

Provided that if there be more than one dependant under clause (b), the amount payable under this clause shall be equally divided between them.

(2) (a) The daily rate of dependants' benefit shall be fifty per cent more than the 'standard benefit rate' specified in Rule 54 rounded to the next higher multiple of five paise corresponding to the average daily wages in the contribution period corresponding to the benefit period in which the employment injury occurs.

(b) Where an employment injury occurs before the commencement of the first benefit period in respect of a person, the daily rate of dependants' benefit shall be :-

(i) where a person sustains employment injury after the expiry of the first wage period in the contribution period in which the injury occurs, the rate, fifty per cent more than the standard benefit rate, rounded to the next higher multiple of five paise corresponding to the wage group in which his average daily wages during that wage period, fall;

(ii) where a person sustains employment injury before the expiry of the first wage period in the contribution period in which the injury occurs, the rate, fifty per cent more than the standard benefit rate, rounded to the next higher multiple of five paise corresponding to the group in which wages actually earned or which would have been earned had he worked for a full day on the date of accident, fall.

The dependants' benefit rate calculated as aforesaid shall be called the "full rate".

L.6.8B. It will be clear from a study of section 52 of the Act and Rule 58 of the Central Rules that dependants' benefit is payable to a widow for life or until remarriage, to each legitimate or adopted son upto the age of 18 years and to each legitimate or adopted daughter upto the age of 18 years or until her marriage whichever is earlier. This benefit is also payable to an infirm son or infirm daughter who has attained 18 years of age provided the infirm son or daughter was wholly dependent on the earnings of the insured person at the time of his death. This benefit is payable to the infirm son so long as his infirmity lasts; in case of daughter so long as her infirmity

lasts or until her marriage even if her infirmity continues. The term 'infirmity' includes physical or mental infirmity and, for entitlement to dependants' benefit, the infirm son/daughter should have total or, in any case, very substantial lack of earning capacity.

L.6.9. A minor son/daughter who was below 18 years but not infirm at the time of insured person's death and who develops an infirmity later on, is not entitled to dependants' benefit for infirmity and the benefit will be stopped in respect of him/her when he/she becomes 18 years old. However, if a minor son/minor unmarried daughter is infirm at the time of insured person's death, his/her dependence on the latter's earnings will be presumed and in order to ensure continuance of dependants' benefit to such an infirm son/infirm unmarried daughter beyond the age of 18 years, it will be advisable for him/her to get his/her infirmity certified by the competent authority just after the insured person's death. The investigating official of Branch Office should suitably guide the guardian, so as to avoid hardship later on when such an infirm son/infirm unmarried daughter attains 18 years of age.

Widowed mother's entitlement

L.6.10 With the amendment of Central Rule 58(*vide* para L.6.8A) widowed mother has become a first – category dependant w.e.f. 1.10.2000 just like widow and children.

Other dependants

L.6.11. Where the insured person does not leave behind any of the dependants mentioned in sub-clause (i), (ia) and (ii) of Section 2(6A), then his parents or if none is alive his paternal grand parents would be entitled to dependants' benefit for life, provided they were wholly or in part dependent on the earnings of the insured person at the time of his death. Besides parents/grand parents, other minor relatives of the deceased listed in items (b) to (f) of item (iii) of Section 2(6A) of the Act would also be entitled to the dependants' benefit, until 18 years of age subject to the condition of their total or partial dependence on the earnings of the insured person at the time of his death.

Full rate of dependants' benefit

L.6.12. The method of calculation of "full rate" of dependants' benefit as given in Rule 58, reproduced above, is exactly the same as the method of calculation of daily rate of temporary disablement benefit. It follows that if an insured person received temporary disablement benefit for a few days after sustaining an employment injury which later resulted in his death, there would not be any need to calculate afresh the "full rate" of dependants' benefit payable in respect of him to his dependants.

Share of widow, children and widowed mother

L.6.13. Rule 58 (1) (A) determines the share of widow, children and widowed mother of the deceased in the manner described in para L.6.8A above.

A few examples of distribution of dependants' benefit to widow(s), children and widowed mother are given below by way of clarification:-

The total of dependants' benefit as distributed amongst the widow(s) child (ren) and widowed mother will not exceed the full rate. Some examples of distribution of dependants' benefit to widow(s) child(ren) and widowed mother are given below by way of clarification:-

<i>Example No.</i>	<i>Number of children</i>	<i>Each child's share</i>	<i>Widowed mother's share</i>	<i>Widow's Share**</i>	<i>Remarks</i>
(a)	1	2/5	2/5	3/5	**In case more than one widow survives, then share of widow will be equally divided among them. Total not to exceed the full rate; hence, the child, widowed mother and widow will get 2/7, 2/7 and 3/7 respectively.

(b)	-	-	2/5	3/5	-
(c)	1	2/5	2/5	*	*No widow surviving. Total payable works out to 4/5 th of the full rate.
(d)	2	2/5, 2/5	-	*	No widows and no widowed mother surviving. Total 4/5 th of full rate.
(e)	3	2/5, 2/5, 2/5	2/5	*	Total not to exceed full rate of benefit; hence each one will get 2/8.
(f)	2	2/5, 2/5	2/5	3/5	Each child will get 2/9, widowed mother 2/9 and widow 3/9. If there are 2 widows, each widow will get 3/18 of full rate.

Share of other dependants

L.6.14. In case the deceased person does not leave a widow or legitimate or adopted child, or widowed mother, dependants' benefit shall be payable to the other dependents in the manner stated in Rule 58(I) (B) reproduced in para L.6.8A.

L.6.15. It has, however, to be noted that the existence of dependants as well as their dependence, partial or total, has to be seen at the time of death of the insured person and not on a date before or after his death. The only exception to this principle is a posthumous child born to the eligible widow from the deceased insured person.

Review of dependants' benefit:

L.6.16. Section 55A of the Act says as follows:

55A(1) Any decision awarding dependants' benefit under this Act may be reviewed at any time by the Corporation if it is satisfied by fresh evidence that the decision was given in consequence of non-disclosure or misrepresentation by the claimant or any other person of a material fact (whether the non-disclosure or misrepresentation was or was not fraudulent) or that the decision is no longer in accordance with this Act due to any birth or death or due to the marriage, remarriage or cessation of infirmity of, or attainment of the age of eighteen years, by a claimant.

(2) Subject to the provisions of this Act, the Corporation may, on such review as aforesaid, direct that the dependants' benefit be continued, increased, reduced or discontinued.

L.6.17. Regulation 84 on the above subject states as under:

84(1) The amounts payable as dependants' benefit in respect of the death of an insured person may be reviewed by the appropriate Regional Office at its own initiative, and shall be so reviewed if an application is made to that effect, under any of the following circumstances :-

- (a) If any of the beneficiaries ceases to be entitled to the dependants' benefit by reason of marriage, remarriage, death, age or otherwise, or
- (b) if a fresh dependant is admitted to the claim for dependants' benefit by the birth of a posthumous child, or
- (c) if, after the previous decision as to the distribution of the dependants' benefit was taken, some facts materially affecting such distribution come to light.

(2) Any review under this regulation shall be made after giving due notice by registered post to each of the dependants, stating therein the reasons for the proposed review and giving them an opportunity to submit objections, if any, to such review.

Subject to the provisions of the Act and these regulations, the appropriate Regional Office may, as a result of such review, commence, continue, increase, reduce or discontinue from such date, as it may decide, the share of any of the dependants.

L.6.18. A review of the eligibility and share of each dependant will be necessary in the following circumstances:

(i) **A posthumous child is born to the widow from deceased insured person:**

The dependants' benefit will be reviewed with effect from the date of birth of the posthumous child and share of dependants fixed/refixed in the light of position prevailing on the said date.

Illustration I: Insured person died childless on 1.5.2009 and widow started getting $3/5^{\text{th}}$ of the full rate with effect from 2.5.2009. She gave birth to a living child on 1.10.2009. While there will be no change in the rate of dependants' benefit payable to her, dependants' benefit at $2/5^{\text{th}}$ of the full rate will become payable in respect of the new-born with effect from 1.10.2009.

Illustration II: Insured person died on 1.8.2008 leaving behind his widow and 2 minor children. The rates of dependants' benefit were fixed as $3/7^{\text{th}}$ for the widow and $2/7^{\text{th}}$ each for the two children. A posthumous child was born to the widow on 15.12.2008. The rates on review of dependants' benefit will be fixed as $3/9^{\text{th}}$ i. e., $1/3^{\text{rd}}$ for the widow and $2/9^{\text{th}}$ in respect of each of the three children with effect from 15.12.2008.

(ii) **A child dependant reaches 18 years of age or dies before reaching this age**

OR

A female child gets married before she reaches 18 years of age:

In case of death of a child, dependants' benefit will be paid at the rates already fixed upto and including the date of his/her death, and reviewed, to be effective from the date following the date of death. In case of marriage of female child, benefit at the old rate will be payable upto the date preceding the date of marriage and reviewed, to be effective from the date of marriage. Similarly, dependants' benefit will be payable at the old rate in respect of son or unmarried daughter upto the date preceding the date on which he/she becomes eighteen years and reviewed, to be effective from the next day. In case there is a younger son/younger unmarried daughter already admitted as dependant, the total benefit payable will not be affected but only the shares will be redistributed.

Illustration I: A widow and her two children were in receipt of dependants' benefit when her younger child, being a daughter, was married on 15.10.2009. The earlier shares of dependants' benefit, being $3/7^{\text{th}}$ for the widow and $2/7^{\text{th}}$ each for the children, will be refixed as a result of the review as under with effect from 15.10.2009.

Widow	--	$3/5^{\text{th}}$ of the full rate
Elder child	--	$2/5^{\text{th}}$ of the full rate.

Illustration II: A widow and her only son were in receipt of dependants' benefit when her son became 18 years old on 10.12.2008. Dependants' benefit in respect of the son will be stopped with effect from 10.12.2008 and widow will continue to get her own share only, being $3/5^{\text{th}}$ of the full rate, from 10.12.2008.

(iii) **The widow gets remarried or dies:**

In the event of her remarriage, the widow's share will be stopped w.e.f. the date of her remarriage; In the event of her death, her share will be stopped w.e.f. the date following the date of her death. The share of other dependants will be reviewed and refixed from the relevant date.

Illustration : On death of the widow;

The share of each dependant will work out as follows :-

(a) Widow mother was one of the dependants:

No. of Children	Each Child's share	Widow mother's share	Total share
1	2/5	2/5	4/5
2	2/6 each	2/6	6/6 (full)
3	2/8 each	2/8	8/8 (full)

(b) There was no widow mother:

No. of Children	Each Child's share	Total share
1	2/5	2/5
2	2/5 each	4/5
3	2/6 each	6/6 (full)

(iv) **Of the two widows admitted, one dies or gets remarried.**

Date of review will be the same as in three (iii) above. The half of widow's share which was being paid to the widow now deceased/remarried will be relocated in favour of the surviving/remaining widow who will start receiving widow's full share of DB admissible. There will be no change in the rates of DB being paid to other dependants.

(v) **Of the two parents admitted, one dies.**

During their lifetime, each parent was getting 3/20 of the full share of DB. When one of them dies, the share of the deceased parent will be relocated to the surviving parent who will start getting 3/10 of the full rate of DB as admissible to a single parent (other than widow mother) w.e.f. the date following the date of the late parent's death.

(vi) **An infirm child in receipt of dependants' benefit who is above 18 years of age overcomes his/her infirmity:**

Dependants' benefit will be stopped to him/her. On review, other dependants will receive dependants' benefit on reallocation of their shares in the same manner as when a dependant child becomes 18 years old.

Payment when review decision is awaited

L.6.19. Review of dependants' benefit will be carried out normally by the Regional Office at its own initiative or on reference from Branch Office and the Regional Office will ensure issue of revised rates of dependants' benefit admissible to the remaining dependants before the date of termination of benefit to a dependant, e. g., when a dependent child is to be 18 years old. At other times, the Branch Office will initiate a review on coming to know of events like marriage/remarriage of a daughter/widow or death of a dependant and it may take time for the Branch Office to receive the Regional Office decision on review. In cases where the Regional Office decision is awaited and the next payment of dependants' benefit has fallen due, there is no bar to the Branch Office

continuing payment of dependants' benefit at the old rates in respect of those dependants who will obviously continue to be eligible even after the review. The payments thus made can be adjusted against the revised rates received from Regional Office after the review. However, in the following cases the payment may be stopped and the Regional Office review decision awaited:

- (1) When guardianship of dependants has been put to question.
- (2) Information regarding marriage of a daughter, remarriage of a widow or widowed daughter, death of a dependant was received long after the event, and payment for periods after the date of the event has already been made.
- (3) Some material facts putting into doubt the right to benefit of some dependants already admitted have been brought to light.

Date of accrual of dependants' benefit

L.6.20. As per Regulation 83, the dependants' benefit shall accrue from the date of death in respect of which the benefit is payable, or where disablement benefit was payable for that date, from the date following the date of death. It follows also that in case wages were paid for the date of death, dependants' benefit accrues from the date following the date of death.

When claim becomes due

L.6.21. Under Section 77, an application claiming a benefit shall be made before an Employees' Insurance Court within a period of three years from the date on which cause of action arose. The cause of action would be deemed to arise only if the dependants of the deceased insured person had claimed the dependants' benefit in accordance with the Regulations within a period of twelve months after the claim became due. In other words, the claimants should have filed the claim with the Corporation within 12 months of the date on which it became due. Employees' Insurance Court can, however, relax this 12 months' limit on grounds which appear reasonable to the court. Regulation 45 (d) says that a claim for dependants' benefit for the purposes of Section 77 of the Act becomes due for the first payment on the date of death of the insured person or, if disablement benefit was paid for the date of death, on the date following the date of death and, in case of birth of a posthumous child, on the date of birth of the posthumous child. For subsequent payments, as per Regulation 45 (e), the claim for payment of dependants' benefit becomes due on the last day of the month to which it relates.

L.6.22. Thus, the right of a dependant to dependants' benefit is legally enforceable only if he or she submitted a claim for the benefit to the Corporation within 12 months of the date on which it became due and, the same having not been paid by the Corporation, submits an application within 3 years of the said date to the Employees' Insurance Court. The limit of 12 months as aforesaid may be relaxed by the Court on grounds which appear reasonable to the court.

L.6.23. In view of the fact that a vast majority of the dependants may be illiterate and ignorant of the provisions of the law as described above, the Corporation continues to entertain claims for dependants' benefit received later than the legal time-limits. The Regional Director, who is the authority to –

- (i) admit a case of death of an insured person as death due to employment injury,
- (ii) admit a dependant as well as a guardian in case of minor for payment of dependants' benefit and,
- (iii) review and refix the rates of dependants' benefit, has also the power to admit a claim received later than 12 months after the date mentioned in paragraph L.6.20 but within 6 years from the said date provided he is satisfied about the reasons for delay. Claims received after the expiry of 6 years are to be referred to Headquarters Office.

When claim becomes payable

L.6.24. Under Regulation 52, the first payment of dependants' benefit must be made not later than 3 months after the claims therefor, together with the relevant medical or other certificates and any other documentary evidence which may be called for under the Regulations has been furnished complete in all particulars to the Regional Office. Subsequent payments have to be made within the calendar month following the month to the whole or part of which they relate, whichever is later, subject to production of any documentary evidence which may be required under the Regulations.

L.6.24A. Where payment is not made within the time limit stated above, it has to be reported to the appropriate Regional Office and must be made as soon as possible.

Increases in the rates of dependants' benefit

L.6.25. Keeping in view the rising cost of living and with the interests of the dependants as its core objective, the Corporation has, from time to time, sanctioned increases in basic rates of dependants' benefit as under :-

Table of enhancement of dependants' benefit rates

Date of employment Injury	Increases in basic rate of benefit allowed from				
	1-10-77	1-4-80	1-1-87	1-1-89	1-1-92 (See note 1 below)
(a) On or before 31-3-74	20%	20%	45%	10%	45%
(b) 1-4-74 to 31-3-75	10%	20%	45%	10%	35%
(c) 1-4-75 to 31-3-78	--	15%	45%	10%	35%
(d) 1-4-78 to 31-3-79	--	--	45%	10%	35%
(e) 1-4-79 to 31-3-81	--	--	35%	10%	30%
(f) 1-4-81 to 31-3-84	--	--	15%	10%	30%
(g) 1-4-84 to 31-12-86	--	--	--	10%	25%
(h) 1-1-87 to 31-3-90	--	--	--	--	15%

In addition to the increases mentioned in the table given above, the Corporation has effected seven more increases effective from 1.1.93, 1.4.95, 1.8.97, 1.8.99, 1.8.2000, 1.8.2002 and 1.8.2005. In each case the periods mentioned in the first column in the above table were spread over to a very great extent and each period of a calendar year was given a separate increase.

Note 1: The full rate of dependants' benefit after enhancement should not exceed the maximum full rate of dependants' benefit which was :-

Rs. 18.75 upto 31-12-80

Rs. 21.00 from 1-1-81 to 26-1-85

Rs. 28.00 with effect from 27-1-85

However, the maximum limits as stated above are not applicable to increases in dependants' benefit rates sanctioned after 1-1-89, as the rates are revised from time to time regularly.

Note 2: When fractions of paise occur in the increased rates of each dependent, these should be rounded off to two decimal points, e. g., 35.9375 paise to 35.94 paise and 10.8635 paise to 10.86 paise.

Note 3: The quantum of enhancement in DB rates upto the increase effected on 1-1-92 is to be allowed with reference to the date of employment injury and not with reference to the date of death of insured person. However, the quantum of enhancement effected from 1-1-93, 1-4-95, 1-8-97, 1.8.99, 1.8.2002 and 1.8.2005 is to be allowed with reference to the date of death of insured person due to employment injury.

Note 4: The increase in DB rates is to be allowed on "basic amount". Basic amount means dependants' benefit rate which was originally payable before allowing any increase.

Note 5: For calculation of actual dependants' benefit rate under each slab admissible on account of the increases sanctioned Hqrs. memos, copies of which were supplied to all the Branch Offices, have to be referred to.

Special increase in case of lowest wage groups

L.6.26. In respect of lower wage groups, the Corporation has given an additional relief effective from 1-1-90 onwards, and thereby the daily rate of DB for the lowest four wage groups has been raised to Rs. 14/-, as per details given below:-

<i>S. No.</i>	<i>Group of employees whose daily wages are</i>	<i>Existing full daily rate of DB</i>	<i>Enhanced full daily rate of DB</i>
1.	Below Rs. 6/-	3.50	14.00
2.	Rs. 6/- and above but below Rs. 8/-	4.90	14.00
3.	Rs. 8/- and above but below Rs. 12/-	7.00	14.00
4.	Rs. 12/- and above but below Rs. 16/-	9.80	14.00

The full rate of dependants' benefit in case of the above mentioned four groups shall be either Rs. 14/- or that worked out inclusive of increases effected from time to time in the basic rate, whichever is higher.

CHAPTER VI

DEPENDANTS' BENEFIT PROCEDURE

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CHAPTER VI

DEPENDANTS' BENEFIT PROCEDURE

Death due to employment injury

P.6.1. A dependants' benefit claim can arise only on the death of an insured person during the course and out of an employment injury. Death due to an employment injury may occur either (i) instantaneously after the employment injury is sustained or (ii) some time after the employment injury. (Section 52). The term "dependant" has been discussed in the Chapter on Dependants' Benefit Law.

Report of death

P.6.2.1. As per Regulation 77, where fatal accident occurs at the place of employment the employer is required to send a report of death to the nearest Branch Office and to the ESI Dispensary. Further, such a report has to be sent by the employer through a special messenger or otherwise as speedily as possible (Regulation 68). In case death occurs on any day when the Branch Office is closed or beyond its regular working hours, the employer is required to arrange to send the report to the residence of the Branch Manager.

P.6.2.2. If fatal accident occurs outside the premises of factory/establishment while the insured person was on duty, the employer is required to send the accident report to the appropriate Branch Office and the Insurance Medical Officer/Insurance Medical Practitioner of the insured person as soon as he comes to know about fatal accident of the insured person.

Disposal of body of IP who died of employment injury

P.6.3.1. Regulation 78 provides that where an insured person dies as a result of an employment injury sustained as an employee under the Act, the body of the injured person shall not be disposed of until it has been examined by an Insurance Medical Officer who will also arrange a post mortem examination, if considered necessary, in co-operation with any other existing agency.

Provided that if an Insurance Medical Officer is unable to arrive for the examination within 12 hours of such death, the body may be disposed of after obtaining a certificate from such Medical Officer or Practitioner as may be available.

Provided further that nothing contained in this Regulation shall be in derogation of any power conferred on a coroner under any law for the time being in force or on the officer-in-charge of a police station or some other police officer under Section 174 of the Code of Criminal Procedure, 1973 (2 of 1974).

P.6.3.2. The employer will thus wait for the visit of the Insurance Medical Officer and help him in completing his enquiries. The body of the injured person shall not be disposed of by the employer or if the body is removed to the residence of the deceased by his relatives, until it has been examined by an Insurance Medical Officer/Insurance Medical Practitioner. If the Insurance Medical Officer/Insurance Medical Practitioner is unable to arrive within 12 hours of the death, the body may be disposed of after obtaining a death certificate from such Medical Officer or Practitioner as may be available.

BM's role on receipt of death report

P.6.4. On receipt of form 16 (form 12 w.e.f. 1.1.05) or report of death in the Branch Office, the Manager shall give top priority to the matter, enter the same in the Accident Report Register and visit the place of accident personally at the earliest. If the report reaches him beyond working hours of the Branch Office or at his residence, arrangement will be made by him to visit the factory/establishment as early as possible. It is emphasised that all such accidents will be investigated by the Manager or the Dy. Manager himself immediately and, in any case, within three days from the date of receipt of the accident report. The Manager/Dy. Manager will also ascertain the wage-

cum-contribution record of the deceased person. Where an ESIC-32 or wage-cum-contribution record has been already furnished by the employer, the Manager will check its correctness with the original wage records. He should also simultaneously obtain the claim(s) from the eligible claimant(s). For this, the BM should seek the co-operation of the employer, the trade union and the co-workers. He will then prepare his report on form ESIC-25 (a copy of which may be seen at Annexure – I, Chapter-IV-TDB Procedure). This report together with the wage-cum-contribution record duly verified by him and the accident report will be entered in the Accident Report Register in the appropriate column as usual, and despatched to Regional Office alongwith the claim(s) obtained from eligible claimant(s) and other documents detailed in Chapter IV - Temporary Disablement Benefit Procedure, within ten days of the date of receipt of the accident report.

P.6.5. In the mean time the dependants (widow, widowed mother and/or children) of the deceased insured person may contact the Branch Office in connection with dependants' benefit. The receptionist/claims clerk will receive them and supply them with the necessary forms and furnish all information needed by them. He will also assist them in filling up the claim form (form 15), specimen at Annexure I. Enquiries may also have to be made from the dependants by post in which case the necessary forms will be despatched alongwith brief instructions regarding the legal requirements and procedure to be followed in filling and sending the claim forms to the Branch Office.

Admittance of death case by BM

P.6.5A In case the accident takes place inside the factory premises (shop floor) arising out of and during the course of employment and Branch Manager finds on investigation that the death has occurred due to employment injury, he may admit the case and take further action for provisional payment of dependants' benefit after obtaining an undertaking as per specimen below. The provisional payment of dependants' benefit may be made for a maximum period of six months and the payments thus made may be adjusted on receipt of final decision on the death case from Regional Office.

UNDERTAKING

I, _____ son/daughter/wife of late Shri _____, Ins.No. _____ an employee of M/s _____ hereby declare that I am a bonafide dependant of the insured person named _____ who expired due to accident in the factory on _____.

I claim advance payment of dependants' benefit as per provisions under ESI Act without prejudice to the outcome of the final approval/decision on the case.

I further promise to refund the payment so received by me if the same or part of it is found not payable to me on final decision in the case.

Signature _____
 Name(_____) _____
 Date _____
 Complete address _____

Witness 1. Signature, name and address:-

Witness 2. Signature, name and address:-

(This undertaking on behalf of minor children will be signed by the widow)

Countersigned and accepted for provisional payment of dependants' benefit

Signature _____
 Manager, Branch Office,

Date:

Death occurring some time after employment injury

P.6.6.1. The Branch Manager will also conduct an investigation into such a case on receipt of the information about death. He will proceed to the place of death and examine the eye-witnesses to verify that death had resulted from the employment injury and not from any other cause. The examination of witnesses and their statements should be recorded by him. The Manager should then prepare a report embodying his findings on the case in form ESIC-25.

P.6.6.2. The Manager will, if the investigating Branch Office is also one to which the insured person was attached, hand over his report to the clerk concerned. The clerk will record on the ledger sheet, remarks regarding death of the insured person.

Where IP attached to another Branch Office

P.6.7. If the investigating Branch Office is not the one to which the insured person was attached, the Manager will hand over the death report together with ESIC-25 to the receipt clerk who will make an entry in the remarks column of the accident report register and despatch it to the appropriate Branch Office or where this is not known, to the Regional Office for transmission to the appropriate Branch Office.

Post mortem report

P.6.8.1. On receipt of form-12, or even earlier, on receipt of a message about the death, Insurance Medical Officer/Practitioner will visit the factory/establishment and examine the deceased person's body and the circumstances in which he received the injury. If considered necessary, he will arrange for a post mortem examination of the body in co-operation with any other existing agency.

P.6.8.2. Wherever death occurs from causes other than natural causes, a post mortem examination of the dead body is got conducted as a rule at the initiative of the police. In such cases, the Branch Manager will obtain a copy of the post mortem report on payment of fee at rates prescribed by the State Government.

P.6.8.3. Where post mortem examination is conducted at the request of the Insurance Medical Officer/Insurance Medical Practitioner, the Regional Director or the Branch Manager, the fees should be paid at the rates prescribed by the State Government.

P.6.8.4. The fee will be paid by the Branch Office from A/c No. 2 and shown as a distinct entry in the schedule of benefit payments ESIC-19 in column 26 or any other column of the schedule which has not been utilised, by giving the heading as "fee paid for post mortem". The voucher may be kept by the Branch Office as in the case of benefit payment dockets.

P.6.9. Where the Insurance Medical Officer and the Manager are fully satisfied that the death was due to employment injury, the post mortem examination need not be insisted upon. In other words, where there is no doubt about the death having resulted from an employment injury, a post mortem report need not be insisted upon as a matter of routine and the case may be disposed of speedily without waiting for the post mortem report.

P.6.10. Where, however, it is found unavoidable or essential to call for a post mortem examination report, no effort should be spared by Branch Manager in obtaining the report. But the BM shall not delay the submission of the papers/report due to non-receipt of FIR/Post Mortem Report etc. The Regional Office, on its part, should lend its full support if any State Government authority is to be approached for the purpose.

P.6.11. However, if the post mortem report/death certificate does not become available within two months from the date of death due to accident, the case may be examined and decided by Regional Office based on circumstances of death, with reference to Section 51A of the Act, in consultation with the Medical Referee or the State Medical Commissioner. Please also refer to Para P.6.20.3 *infra* in this connection.

Death certificate

P.6.12. The IMO/IMP will issue a death certificate in form ESIC-Med-12 unless he is certain that the death was due to an employment injury say, for instance, after a post mortem examination, or on a careful examination of the body of the insured person (of which a written record may be kept) and keeping in view the circumstances of the death, in which case he may issue a death certificate in form-17 (Form 13 w.e.f. 1.1.05). ESIC-Med-12 will be equally admissible for purpose of deciding claims for dependants' benefit in place of death certificate in form 13. A death Certificate should ordinarily be issued to dependants and a copy of it may be sent to the appropriate Branch Office. All the records pertaining to the deceased insured person, i. e., the medical record envelope, the index card, etc., will be returned by the Insurance Medical Officer to the Administrative Medical Officer.

Inviting claim in advance of acceptance

P.6.13.1 The dependants of the deceased insured person should be supplied copy of form 15 (specimen at Annexure-I) as soon as the Regional Director or the Branch Manager, as the case may be, *prima facie* comes to the conclusion that the death has been due to the employment injury. While sending the form to the dependants of the deceased insured person, it should, however, be made clear that any claim furnished by him/them will be without prejudice and subject to the Corporation being convinced that death was due to employment injury. Specimen of letter to be issued to dependants is at Annexure II.

P.6.13.2 In order to expedite the claim from the dependants and to cut down delay, notice should instead be issued by the Branch Manager himself. The amended form of the notice is at Annexure II-A.

Watch over progress of DB case

P.6.14. A separate file should be opened for each fatal accident case, which should be marked "DEATH CASE" in red ink on its top and which should remain in the custody of the Branch Manager who should personally ensure that necessary follow-up action in the case is taken on top priority basis at all the stages right from the date of accident to the date of first payment of Dependants' Benefit.

P.6.15. At the Regional Office, the Regional Director should review the position of all pending cases every month. A statement of cases pending in each of the Branch Offices and in the Regional Office, indicating reasons and details of cases pending for more than 6 months from the date of accident, reasons therefor and steps taken to dispose of the same should be sent so as to reach the Headquarters Office by 15th of the month following the month to which it relates. This statement should be sent under the signatures of the Regional Director.

Dependants' benefit claim

P.6.16. The dependants' benefit claim form (form 15 – copy at Annexure I) may be filled in individually by each dependant or jointly by all or some of the dependants. It must be attested by one of the authorities mentioned on the form and be accompanied by the following documents:-

- (a) Evidence that death of the insured person has occurred due to an employment injury in shape of a death certificate issued by an Insurance Medical Officer/Insurance Medical Practitioner on form 13 or ESIC-Med-12, or a certificate of death issued by a hospital or dispensary doctor, or any other medical practitioner who may have been on the spot at the time of death or visited the deceased after death. Municipal death certificate supported by evidence that the insured person died due to employment injury will also be sufficient for the purpose. If the original death certificate is required by the dependents for any legitimate purpose, it may be returned on written request after retaining a copy thereof duly attested by the Manager. This may be done only after the claim has been decided.

- (b) Evidence that the claimant/claimants is/are dependant(s). This evidence may be in the form of a declaration by the claimant, supported by a certificate signed by an authority named in Form 15 (see Annexure I)
- (c) Evidence of the age of claimant. Proof of the age may be given by means of any of the following documents which should normally be insisted upon:-
- (i) Certified extract from an official record of births showing the date and place of birth and father's name.
 - (ii) Original horoscope prepared soon after birth.
 - (iii) Certified extract from baptismal register.
 - (iv) Certified extract from school records showing the date of birth and father's name.
 - (v) If the Regional Director has reasonable doubts about the horoscope having been prepared soon after the birth he may not accept the same. The question of a horoscope being original or otherwise in terms of Regulation 80(2)(b) is entirely for the Regional Director to decide. If once a horoscope as furnished by the dependant is found *bona fide* and accepted by the Regional Director as a valid proof of age, the decision is final and audit need not question the decision.
 - (vi) Where the exact date of birth is not available, it may be determined as under:-
 - (aa) Where only the year of birth is available, but not the month of birth, date of birth should be assumed to be 1st July of the year of birth.
 - (bb) Where the month and the year of birth are known, but not the date of birth, the date of birth should be taken as the 16th day of the month.
 - (vii) Where there is no proof of age of dependant or the proof furnished is not acceptable to Regional Office or Branch Office, the Medical Referee or Medical Officer Incharge of Government Hospital/Dispensary (at places where the Medical Referee is not available) will determine the age. The date on which the age is determined will become the date of birth of the dependant reduced by the number of years of age as is determined on the date of examination. For instance, if a minor son is found to be 11 years old on 6.3.2001, his date of birth will be assumed as 6.3.1990 and dependants' benefit will be payable upto 5.3.2008.
- (d) Evidence that the female dependant/s (widow/s or daughter/s) has/have not married or re-married after the death of the insured person-A certificate of Magistrate, a Sarpanch of village, or a Municipal Commissioner or a serving Gazetted Officer of the State or Central Government may be sufficient for this purpose.
- (e) Evidence regarding infirmity of the dependant for entitlement to dependants' benefit: This may be obtained in the form of a certificate from such medical officer or other authority as may be specified by the Director General. Every Medical Referee of the ESI Corporation has been authorised by the Director General to issue such a certificate. The suggested proforma of certificate of infirmity may be found at Annexure II B (See also para P.6.38).

Examination of claim

P.6.17. The dealing clerk will examine the documents and see that they are in order. If all the documents are not there, the clerk will explain to the dependant(s) what documents are missing and also how and from what authority or authorities the claimant(s) could obtain them. If the death certificate on form 13 or ESIC-Med-12 issued by an Insurance Medical Officer to any one of the dependants has been produced, then the other dependants need not produce the death certificate.

P.6.18. In case claim on form 15 (Annexure I) has been received by post, the claims clerk concerned will, after examining the claim and the supporting documents, invite the attention of the claimant(s) to the defective or missing documents, if any, pointing out the defects in each and advising them how to correct them or how to obtain the missing documents. The letter will be signed by the Manager.

P.6.19. When the claims brought personally by the claimants have been properly completed alongwith supporting documents, the clerk concerned will further examine them on the following points:-

- (a) Whether the death has occurred due to employment injury.
- (b) Whether, in the opinion of the Branch Office, the claimants fall in the category of dependants.
- (c) Whether the papers are complete and all formalities have been complied with.

He will then obtain orders of the Manager and arrange to despatch the papers to the Regional Office with a covering letter giving the result of the examination. Correspondence with any outside party, i. e., the Insurance Medical Officer, the employer, the Regional Office, etc., should be kept in the file of the deceased person. When completed claims are sent to the Regional Office an entry in the ledger sheet will be made by the claims clerk concerned. The Branch Office will then await instructions of the Regional Office. Any further particulars required by the Regional Office on any points will be promptly furnished to the Regional Office.

Time-bound action at RO

P.6.20.1 Benefit branch at Regional Office should process the case within 7 days from the date of receipt of papers and case must be decided and sent to the Finance Division who will convey their concurrence within 7 days of receipt and return the file to the Benefit Branch, whereafter the papers will be submitted to Regional Director for his decision to accept the case as one of death due to employment injury. Decision should be communicated to all concerned within 7 days.

P.6.20.2 In doubtful cases the Regional Office may consult Medical Referee/SMC for his opinion which should be obtained as early as possible but, in any case, within 7 days from the date of the reference to MR/SMC.

P.6.20.3 Para P.6.11. *supra* provides for waiting for post mortem report/chemical analysis report for 2 months in respect of cases where the cause of death is not known or the case is doubtful. The Regional Director is advised to take decision in such cases also without waiting for such report depending on the circumstances and its merits. Doubtful cases may, however, be rejected. On receipt of chemical analysis report/post mortem report, the case may, if found justifiable, be reopened and reconsidered if the evidence/findings are favourable to the case.

Completion of Regional Office dependants' register (ESIC-102)

P.6.21. When the decision has been taken that the death is due to employment injury, entries will be made in the Regional Office dependants' register in form ESIC-102. At this stage, columns 1 to 7 will be filled up. Regional Office may in the meantime also receive the dependants' benefit claims from the Branch Office. Entry will then be made in column 8 of the dependants' register. For each death case, five lines may be reserved so that particulars of all dependants can be entered.

P.6.22. The Regional Office will make enquiries and collect the information regarding the persons who claim to be dependants, either from the Branch Office to which the deceased insured person was allotted, or wherever possible, independently. In case these persons live locally, enquiries may be conducted by the Regional Office. Direct enquiries may be made by the Regional Office in cases where these dependants are living outside, by addressing letters to the office bearers of the gram panchayat, and to the known relatives of the deceased person or even through the employer. Efforts should be made to obtain as much documentary evidence as possible. When the enquiry is complete, the Regional Office will examine whether any dependant (s) exist who have not yet submitted their claims.

Inviting claims from 'other' dependants

P.6.23. The Regional Office will also issue a notice under registered cover to all dependants whose particulars might have been given on the back side of the claim form (form 15) by claimants, or who appear to be dependants as a result of the enquiry conducted by the Branch Office or the Regional Office. The notice will be in writing in form ESIC-101 (Annexure III), requesting for a reply within thirty days from the date of such notice. Thereafter, column 9 of the dependants' register should be filled in.

Note:- The notice above-mentioned will be necessary only where the BM has not already issued the same to the 'other' dependants and obtained and enclosed with the reply with the papers sent by him.

General notice where necessary

P.6.24.1 In addition to the notice to known dependants, the Regional Office may give a general notice intimating the death of the deceased person and inviting claims within 30 days of the date of such notice, from persons who consider themselves to be eligible for dependants' benefit under the Act.

P.6.24.2 This general notice will be given, if considered necessary, by issuing an advertisement in the Branchpaper and/or by displaying it through pasting or otherwise –

- (1) at the place of the last employment and the last residence of the deceased person;
- (2) at the permanent residence of the deceased person;
- (3) at the appropriate post office;
- (4) on the notice board;
- (5) at Regional Office, Branch Office and the ESI dispensary to which he was attached.

Regional Office decision on dependants' benefit

P.6.25.1. After a lapse of 30 days from the issue of notice, the Regional Office will consider all the claims received and decide as to who are the eligible dependants of the deceased person. The Regional Office will satisfy itself about the following:-

- (i) That the relationship to the deceased claimed by each dependant is borne out by corroborating information given by the other dependants or collected from independent enquiries.
- (ii) That the documentary evidence relating to age and marital status of each dependant is satisfactory. Documentary evidence of age in regard to widow is not essential and may not be insisted upon.
- (iii) That the person signing the claim for and on behalf of minor claimants is acceptable as a guardian to the Corporation. For this, a widowed mother, even if she remarries, is accepted as a natural

guardian of her minor children from the deceased insured person. However, a Muslim mother is not the natural or *de jure* guardian of her children from the deceased insured person and it is the paternal grand father who is the legal guardian of a Muslim minor in the absence of his father. Nevertheless, the Muslim widow may be accepted as a *de-facto* guardian provided she declares in writing that she has the custody of the person and property of the minor dependant(s) and will spend the dependants' benefit for his/her/their care and maintenance. This declaration should be obtained at the time of obtaining form 15 and should be got attested from the same authorities as are to attest prescribed form 15.

- (iv) That an infirm child's evidence (a) in support of his/her infirmity and (b) his/her complete dependence on his/her father/mother's earning is satisfactory.
- (v) In case any adopted children claim dependants' benefit, a certificate regarding their adoption from competent court of law certifying their adoption by the deceased insured person may be deemed valid. Similar will be the position if adoptive parents submit a claim for dependants' benefit.

The Regional Office will determine the persons who are entitled to dependants' benefit and the share to which each one is entitled. For method of calculating the share of each dependant, reference may be made to the 'Law' part of this Chapter.

P.6.25.2. The daily rate of dependants' benefit for each dependant will be calculated and entered in the dependants' register. Each rate thus calculated will not be rounded off and will be shown in fractions of paise only. Solved example is in para L.6.25- Note. 2.

P.6.25.3. In case the deceased person does not leave a widow, widowed mother or child, other dependants specified in Central Rule 58(1)(B) will be considered. Before admitting a claim from the parents other than a widowed mother and the grand parents and/or minor dependants, the Regional Office should ensure that they were wholly or partially dependent on the earnings of the deceased insured person at the time of his death. For this purpose, a declaration in the following form duly attested by any of the authorities mentioned therein may be accepted:-

**Certificate of dependence to be submitted by dependant
other than widow, son, daughter and widowed mother**

Certified that I/we were wholly/partially dependent upon the earnings of the deceased Shri
..... Insurance No.....at the time of his death

S. No.	Name	Father's/ Husband's Name	Relationship to deceased	Signature/ Thumb impression	Date
1	2	3	4	5	6
1.					
2.					
3.					

Certified that the above declaration is correct to my knowledge and belief.

Signature:

Designation:

Rubber Stamp:

Note 1:- In case of minor, signature in column 5 should be recorded by his/her guardian in column 5.

Note 2:- This form may be got attested from any one of the following authorities :-

(i) An officer of revenue, judicial or magisterial department of Government; or (ii) a Municipal Commissioner; or (iii) a Workmen's compensation Commissioner; or (iv) the head of gram panchayat under the official seal of the panchayat; or (v) a Member of Parliament; or (vi) a Member of Legislative Assembly; or (vii) a member of Standing Committee or of the Employees' State Insurance Corporation; or (viii) a Member of Regional Board or Local Committee of the Corporation.

Advance (provisional) payment of dependants' benefit

P.6.26. Stringent steps have been prescribed at every level for avoiding any possible delay in settling the claims of the dependants for dependants' benefit and starting regular monthly payments. However, at times, despite the best intentions of all concerned, unavoidable delays do occur in the settlement of dependants' benefit, the remedy for which may not be in the hands of the Corporation's functionaries. The ESI Corporation has, therefore, decided to introduce a scheme of advance payment of dependants' benefit on the same lines as in the case of advance payments of permanent disablement benefit. The procedure to be followed is described below:-

- (1) At the time of investigation of a fatal accident, the Branch Manager may also examine the title of the claimants to the dependants' benefit, obtain claim forms (Form 15) etc. from the widow for herself and minor children etc. alongwith necessary proof of age of minor children. All other formalities required for payment of dependants' benefit may be completed at the time of investigation of the death case on the assumption that it will be accepted as a case of death due to employment injury by the competent authority. In case the particulars of the widow or the minor children etc. are not available, their address etc. should be obtained from the deceased insured person's employer whom he last served and claim forms etc. sent by registered post with necessary guidelines to complete the same.
- (2) Every fatal accident case may be processed in the Regional Office/Branch Office on priority basis. The Regional Director while accepting a case as that of death due to employment injury may also pass orders to allow 75% of the dependants' benefit admissible to the widow and minor children without the concurrence of the Finance Division. However, in fatal cases admitted by Branch Manager as per P.6.5A, the Branch Manager is empowered to make provisional DB payments to the dependants for a maximum period of six months.
- (3) The advance (provisional) payment of dependants' benefit would be admissible for a period of six months. The Regional Director/Branch Manager should ensure that all formalities are completed and the case is finally decided within this period.
- (4) The rate of advance payment (75% of the full anticipated rate of dependants' benefit) should be divided between the widow/widow(s), widowed mother if surviving and minor children in the same ratio as prescribed in Rule 58. If the widow is having more than one child and details of age of all children are not readily available, the share of widow as well as widowed mother and child/children whose entitlement is established may be released and the shares of other children may be withheld. On finalisation of the rate and the title of claimants, the share of each dependant admitted may be divided/adjusted as per instructions.
- (5) The advance (provisional) payment of dependants' benefit to the widow, widowed mother and minor children would be subject to review if the widow re-marries or any of the children attains the age of 18 years within the period of six months for which the provisional rate is valid.
- (6) Where deceased person is not survived by his widow, widowed mother and minor children, claims of other dependants for provisional payment may also be examined by the Regional Director at the time of accepting the case as death due to employment injury. In all such cases, the advance (provisional)

payment shall be allowed to the eligible dependant(s) to the extent of 75% of the amount of benefit admissible as per procedure outlined in the foregoing paras.

- (7) The said advance (provisional) payment will be subject to a written undertaking to be obtained from each claimant in the following form before releasing the payment:

UNDERTAKING

I have requested the Branch Manager, ESI Corporation _____ for making advance (provisional) payment of the dependants' benefit to me. I undertake to refund the amount of the overpayment, if any, made to me on this account.

(NAME AND SIGNATURE OR THUMB IMPRESSION
OF THE CLAIMANT)

(NAME AND INSURANCE NO. OF THE
DECEASED INSURED PERSON)

This undertaking on behalf of minor children will be signed by the widow.

- (8) The amount of benefit paid in advance (provisionally) shall be adjusted against periodical payments on the basis of finally approved rates and in case of any excess payment, it shall be refunded/adjusted against future payments.
- (9) All instructions/guidelines laid down for payment of dependants' benefit would also apply *mutatis mutandis* to advance payment of dependants' benefit.
- (10) Regional Office and Branch Office should give wide publicity to the facility of advance (provisional) payment of dependants' benefit by every means, e. g., notice board, circular letters to employers, trade unions and at seminars, meetings addressed by Regional Director and other Officers.

Communication of decision on dependants' benefit

P.6.27.1. Regional Office will communicate its decision to all the persons who claimed the dependants' benefit. To those who are not entitled, a letter in form ESIC-146 (Annexure IV) will explain why their claims have been rejected. For those who are entitled, a letter in form ESIC-147 (Annexure V) will indicate the daily rate of benefit of each dependant. For minor dependants, intimation will be sent through the person accepted as their guardian. The Regional Office will send one form 18A (form 16 w.e.f. 1.1.2005) (Annexure VI) for each dependant, after filling it up upto the last day of the previous month and advise the dependant to present it at Branch Office. The Regional Office will also communicate to the Branch Office its decision alongwith rate of benefit for each dependant, the name of guardian, and the last date upto which benefit is payable in respect of each minor dependant.

P.6.27.2. At the time of communicating decision to dependants as well as to the Branch Office, the Regional Office will complete all the remaining entries in the dependants' register. The earliest date on which each minor dependant will cease to be entitled to dependants' benefit on attainment of 18 years of age will be noted in column 14 as the review date against all such dependants.

Completion of records at Branch Office

P.6.28.1. On receipt of the decision of the Regional Office, entries should be made in the Branch Office dependants' benefit register in form ESIC-40 (Annexure VII) in which a separate page will be allotted to each dependant and page numbers thus allotted to each dependant will be indicated in the page index. The claims clerk will complete the entries at the top and on the left hand margin of the page allotted to each dependant. The papers received from the Regional Office will be placed in the file of the deceased insured person.

P.6.28.2. The Manager will check all entries at the top and left hand margin on ESIC-40 and sign at the right hand top corner and at the foot of left hand margin with date. He will also attest the rate admissible to the dependants. Benefit will accrue from the date of death of the insured person. But if temporary disablement benefit was payable for the date of death or wages were payable for that date, dependants' benefit will accrue from the date following the date of death.

P.6.29. The first claim may then be awaited but if it is not received within reasonable time after the date on which Regional Office communicated the decision to the claimants, the dependants may be reminded.

Action where benefit not claimed

P.6.30.1. Under Section 77(1A) of the Act read with Regulation 45(d), a dependants' benefit claim becomes time-barred on the expiry of 12 months from the date of death of the insured person. Cases of dependants' benefit where claim is not received from dependants within 12 months of the death of the insured person should be closed provided the following steps have been completed:-

- (i) The accident has been investigated and the question of employment injury decided.
- (ii) Procedure for inviting claims and issuing notices has been fully complied with.
- (iii) Attempt has been made to locate dependants, among other things, by enquiry through the employer and through a visit by a Corporation official to the place of residence of the insured person at the time of accident. The visiting official should also ask the whereabouts of the dependants from the immediate neighbours of the deceased. The visit is necessary only in those areas where there is a Branch Office or a pay office visited by Branch Office Cashier at the place of accident.
- (iv) The last letter has been sent by registered post.

P.6.30.2. In the rare event that a claimant comes forward at a later date, the claim may be admitted after condonation of delay in the usual manner.

P.6.30.3. No case shall be closed because the claim, though received, is incomplete.

First payment of dependants' benefit

P.6.31. The first payment of dependants' benefit shall invariably be made at the Branch Office and not by money order. When the dependants visit the Branch Office for the first time after receipt of Regional Office intimation, the following procedure will be followed for payment of dependants' benefit to them : -

- (a) The dependants will be properly identified by Manager if not already done and, once satisfied, the Manager will enter the identification marks of each dependant at the appropriate place in the page allotted to each in the register in ESIC-40, and attest the same. The Manager will also ascertain whether further payments will be more convenient at any other Branch Office.
- (b) If entries have not already been made in the dependants' benefit register in the manner described in the foregoing paras, the same will be done at the time of the first visit by the dependants.
- (c) The claims clerk will obtain claim from each dependant in form 16 upto the last date of the preceding month as was indicated by Regional Office while sending this form to the dependants, make entries in the dependants' benefit register, prepare benefit payment docket as usual and pass on register to the checker who, after checking, will pass it on to the Manager. Separate dockets will be prepared for each eligible dependant and the total amount of benefit payable to each will be rounded off in the same manner as in the case of other benefits.

- (d) The Manager will check all papers and entries and sign/initial in columns meant for him in the register, and sign the payment docket.
- (e) The register will be sent to the Cashier who will make payment after identification, obtain the discharge of the claimants on the dockets, make entries in benefit payment columns of ESIC-40 (Annexure VII).and in the schedule sheet as usual.

Payment to minors – guardian’s appointment

P.6.32.1. Once a person has been accepted by the Regional Office as a guardian of a minor dependant, there is no need to obtain a certificate from the guardian that the dependants' benefit drawn by him is being/will be spent for the maintenance of the minor. However, the desirability of removing a guardian under Regulation 86 can be considered by Regional Office if a complaint against the guardian is received from the minor or from a third party that the minor is being neglected by the guardian.

P.6.32.2. Where the guardian is neither a natural one nor appointed by the Court, he may be removed by Regional Office for –

- (a) abuse of his trust,
- (b) continued failure/incapacity to perform the duties of his trust,
- (c) ill-treatment or neglect of the minor,
- (d) conviction for an offence implying, in the opinion of the Corporation, a defect of character which renders him unfit to be the guardian of the minor,
- (e) having an interest adverse to the faithful performance of his duties,
- (f) his bankruptcy or insolvency.

P.6.32.3. In case the guardian is declared or appointed by the court, the dependants' benefit shall continue to be paid to him till such time he is removed by the court. In this connection, if Regional Office considers in any particular case that a guardian appointed by the court is failing to perform his duties towards the children dependants, it may move the court to appoint another guardian.

P.6.32.4. Where the guardian, though not appointed by the court is a natural guardian e. g., the father, or in his absence, the mother, the benefit shall continue to be paid to such guardian unless there is a serious negligence on his or her part in the proper maintenance of the minor.

P.6.32.5. In case of change of guardianship, any amount of benefit remaining outstanding at the time the change becomes effective should be paid to the person who is guardian at the time of making the payment and not to the person who was the guardian during the period to which the payment relates.

Claim for June and December

P.6.33.1. After payment of the first claim, dependants can claim and receive dependants' benefit at monthly intervals by submitting a claim on the expiry of a month in form 16. However, at the time of claiming benefit for June and December every year, a claimant has to submit a declaration in form 27 (24 w.e.f. 1.1.05) (Annexure VIII). This declaration must be accompanied by a life certificate duly signed by an authority specified in the form itself, under his seal or rubber stamp. (Regulation 107A).

P.6.33.2. The Branch Manager may in addition, ask any claimant for dependants' benefit to present himself personally at the Branch Office and satisfy the Manager about his identity. This power should be exercised sparingly and in no case more frequently than once in six months as provided in Regulation

107B. A person incapacitated by bodily illness or infirmity or a purdah nashin lady cannot be asked to attend the Branch Office personally (Regulation 107B).

P.6.33.3. The fact regarding receipt of the declaration/life certificate may be indicated in the remarks column of the dependants' benefit register. [Please also see paras P.6.16 (e) and P.6.38 regarding certificate of infirmity].

Transfer of benefit record to another Branch Office

P.6.34. If on the first interview of dependants or at any time thereafter, the Manager considers that payment of benefit will be more convenient to them at another Branch Office, he should obtain a written request from the dependants for change of Branch Office along with their latest postal address and transfer the records to the new Branch Office along with their latest postal address under intimation to Regional Office. If the Branch Office is under another region, transfer should be effected only after the case has been admitted as one of death due to employment injury and complete papers alongwith full rate of dependants' benefit, the rate payable to each dependant duly audited along with his/her latest postal address directly to the new Branch Office under intimation to both the Regional Offices. In either case, care should be taken that even flow of the periodical payments is not interrupted due to transfer of the case.

P.6.35. In every case of transfer of a dependants' benefit case from one Branch Office to another, the following documents must be sent under registered AD post.

1. Certified copy of ESIC-40 record upto 3 years preceding the date of transfer.
2. A certified copy of the Regional Office decision awarding the benefit.
3. Other correspondence having a bearing on the case.

The effective date of such transfer should be intimated to the dependant concerned.

ECS facility for dependants' benefit

P.6.35A Corporation has extended the ECS facility for monthly payments of dependents' benefit to the beneficiaries. The procedure to be adopted will be on the lines of the procedure detailed in para P.5.51 A in respect of permanent disablement benefit (Chapter V).

Payment by money order

P.6.36. Payment of dependants' benefit except first payment can be made by money order at the cost of the Corporation in the same manner as in the case of other benefits subject to special stipulation in the foregoing paragraphs in case of payments for June and December.

Certificate of infirmity

P.6.37. An infirm son or an infirm unmarried daughter is entitled to dependants' benefit so long as his/her infirmity lasts even after he/she has attained the age of 18 years provided he/she was wholly dependant on his/her father's/mother's earnings during his/her life-time. Regional Office will send intimation accepting the dependant child as infirm and entitled to dependants' benefit. Payment of dependants' benefit is admissible to a minor dependant irrespective of his/her infirmity, but on attaining 18 years of age this benefit can be continued to him/her only if he/she submits a certificate of infirmity from the Medical Referee and the same is accepted by Regional Office as entitling him/her to continued payment of dependants' benefit.

P.6.38. On receipt of intimation from Regional Office, the same will be filed by the claims clerk in the relevant file of the deceased insured person. This will be followed by a certificate of infirmity obtained every year from the Medical Referee. The period of one year, for submission of the next certificate of

infirmity, will be calculated with reference to the date on which this certificate is obtained and submitted for the first time. Since the certificate in form 27 (form 24 w.e.f. 1.1.05) is to be submitted twice a year i. e. for June and December every year, the Branch Office will continue to make payments upto the date on which the next certificate of infirmity or declaration in form 24 is due, whichever is earlier. Due date should be mentioned in ESIC-40. Steps should be taken to obtain those documents well before the review date, so that continuity of payment is not affected. A proforma suggested for certificate of infirmity to be given by Medical Referee is at Annexure IIB.

Review of dependants' benefit

P.6.39.1. The Regional Office may receive either directly or through a Branch Office an application or a representation from a person who might be interested in the review of the dependants' benefit. It is possible that such an application or a representation may not be received from the interested person but the fact on account of which a review may be necessary may come to the notice of the Branch Manager while he is making enquiries on any point relating to payment of dependants' benefit. He should send full report of the fact to the Regional Office stating the circumstances on account of which a review may be necessary, e. g.,

- (i) death of dependant;
- (ii) birth of a posthumous child;
- (iii) remarriage of the widow;
- (iv) marriage of the daughter, and
- (v) termination of the infirmity of an infirm dependant by the Medical Referee.

P.6.39.2. Besides cases where review is initiated by means of a representation, there will be cases where review is automatic by reason of the fact that the dependant attains the age of 18 years. This will already have been noted as review date as explained above.

P.6.39.3. In case of routine review of this nature, e. g., where dependants' benefit will be stopped as the eldest child is going to become 18 years old and dependants' benefit is to be redistributed amongst other dependants as a result of review, BM will no doubt await review decision of Regional Office, but, at the same time, he may continue payment of dependants' benefit at the old rate in respect of other dependants whose dependants' benefit rate is expected to be raised as a result of review. On receipt of review decision from RO, BM may make adjustments with the next payment of dependants' benefit.

P.6.39.4. In cases where the rates of dependants' benefit admissible to dependants were fixed by the Employees' Insurance Court before the enforcement of ESI (Amendment) Act, 1966, the E. I. Court alone can increase the rates of benefits admissible to the remaining dependants. In other words, such cases shall continue to be governed by the provisions of the principal Act for application, appeal or other proceeding relating to such payments or for review by the E. I. Court.

P.6.39.5. A representation informing the birth of a posthumous child to the insured person's widow, supported by a certificate of birth showing the date and place of birth and the father's name would be sufficient ground for a review of dependants' benefit. Similarly, an intimation about the death of dependant supported by certified extract from the birth and death register or a death certificate from a registered medical practitioner or the Sarpanch of the village panchayat, would be sufficient reason for necessitating a review.

P.6.39.6. If a female dependant herself intimates the fact of her marriage/re-marriage in writing, the same may be accepted as sufficient proof of the fact of her marriage/remarriage and the benefit to her may be stopped at once and the rates of benefit of other dependants should be reviewed.

P.6.39.7. If any other beneficiary alleges that a female dependant has married/remarried, the benefit to such female dependant should be suspended. If the allegation is proved, steps for review of the rate of benefit may be taken. If it is disproved, benefit suspended should be resumed. If the party who makes the allegation produces a written statement from the female dependant duly attested by any of the authorities competent to attest six monthly life certificates to the effect that she has married/remarried, then no further proof of marriage/remarriage should be insisted upon but some independent corroboration as to the date of marriage/remarriage should be obtained.

P.6.39.8. If it is discovered that a female dependant has received any dependants' benefit after her marriage or remarriage, the excess benefit paid should be recovered in the same way in which excess payments made on the basis of false declaration regarding abstention from work are recovered. The desirability of taking penal action in these cases should be examined by the Regional Office.

P.6.40. If the Regional Office is convinced that a review is necessary, the following action will be taken :-

- (a) A notice (Annexure IX) will be served by registered post on each of the dependants, stating the reasons for the proposed review and fixing a date for receipt of objections, if any.
- (b) After the expiry of the date fixed for receiving objections, it will consider all the objections raised by the affected dependants, together with documentary evidence that might have been received.
- (c) Regional Office will decide whether review is necessary and, if so, how the other dependants will be affected. Regional Office will then calculate the changed daily rate of benefit admissible to each of the dependants.

P.6.41. The review decision will be communicated by registered post in the form (Annexure X) to the dependants or other persons affected. The Branch Office concerned will also be informed of the Regional Office decision.

Action by Branch Office on review decision

P.6.42. On receipt of Regional Office decision, action will be taken as follows:

- (i) In case there is a new dependant, new sheet in form ESIC-40 will be opened in respect of him/her.
- (ii) In case any dependant has ceased to be dependant as a result of Regional Office review, entry in the column of 'Benefit Terminated' of ESIC-40 will be made as follows :-

“Stopped with effect from on the basis of Regional Office review”

No further payment will be made after the date.

- (iii) In case shares of dependants have been revised and consequently the daily rates of dependants' benefit are changed, the rates will be brought upto date by marking the existing rates as 'Rate in force upto(Period)', the new rate will be written below it in red ink as “current ratewith effect from..... (date)”.

P.6.43. The Branch Office will then continue to make payments or stop them in accordance with the instructions received from the Regional Office.

Payment due on dependant's death

P.6.44. For making payment of dependants' benefit due to any deceased dependant, the procedure as given in paras P.3.80 and P.3.82 of Chapter III – General Claims Procedure may be followed by suitably modifying the form ESIC-63A provided therewith alongwith the surety – indemnity bonds.

**CLAIM FORM FOR DEPENDANT'S BENEFIT
(Regulation 80)**

Name of the deceased Insured Person _____ Ins. No. _____

S/W/D of _____ Date of Death _____

Last employed as _____ by _____

I /we the following, being dependants of the above named deceased Insured Person, hereby claim and accordingly apply for dependant's benefit on account of his/her death :

Name of the dependant	Sex	Age or year of birth	Marital status	Relationship with the deceased	Present Address	Name of the guardian in case of a minor
1.	2.	3.	4.	5.	6.	7.

I/We declare that the particulars given above are true to the best of my/our knowledge and belief.

I/we also declare that to the best of my/our knowledge & belief, there is no other dependant entitled to claim Dependant's Benefit in r/o the death of the above-noted deceased I.P., save and except those mentioned above.

Signature*

- 1.
- 2.
- 3.
- 4.

ATTESTATION**

*Certified that the declarations made above are true to the best of my knowledge and belief.

Name in Block letter and Rubber stamp or seal of the attesting authority
--

Signature

Designation

* All major dependants' should sign individually and the guardian to sign in case of a minor dependant.

**This certificate is to be given by (i) an officer of the Revenue, Judicial or Magisterial Departments of Government; or (ii) a Municipal Commissioner; or (iii) a Workmen's Compensation Commissioner; or (iv) the Head of the Gram-Panchayat under the official seal of the Panchayat; or (v) M.L.A./M.P., (vi) Gazetted Officer, or (vii) a member of Local Committee/Regional Board of the ESI Corporation, or (viii) any other authority considered appropriate by the Branch Manager.

IMPORTANT.- Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend up to six months, or with a fine up to Rs.2,000/-, or with both.

REGIONAL OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

No.

Date:.....

To

Shri/Smt./Kumari.....
.....
.....

Sub: Death case of Shri/Smt.....Ins. No.....

Dear Sir/Madam,

It has been reported to this office that Shri/Smt..... Ins. No..... died on.....as a result of an accident while employed with M/s..... The question whether the insured person died as a result of employment injury is still under consideration. In case it is decided that the death of the above noted insured person was due to employment injury as defined in section 2(8) of the E. S. I. Act, 1948, the following persons may be entitled to dependants' benefit:

1. Widow/widows.
2. Legitimate or adopted son under 18 years of age.
3. Legitimate or adopted unmarried daughter under 18 years of age.
4. Legitimate or adopted son who is infirm and was wholly dependent on the earnings of insured person at the time of his death, till infirmity lasts.
5. Legitimate or adopted unmarried daughter who is infirm and was wholly dependent on the earnings of insured person at the time of his death, till infirmity lasts or until her marriage.

In case the deceased insured person leaves no surviving widow/child, the following persons may be entitled to dependants' benefit: -

- (a) widowed mother
- (b) A parent or grandparent.
- (c) any other –
 - (i) male dependant, until he attains eighteen years of age;
 - (ii) female dependant, until she attains eighteen years of age or until her marriage whichever is earlier or, if widowed, until she attains eighteen years of age or remarriage.

Normally claims for dependants' benefit are invited after the death of the insured person has been accepted as death due to employment injury. However, in order to avoid delay in the settlement of the claim, you are requested to submit the claim in the enclosed form 15 duly filled in and signed and attested by one of the authorities mentioned in the foot-note on the form 15 and documentary proofs of age in case of minor child/children for further consideration in this office. In case you fall under category (b) and (c) above, certificate to the effect that you were wholly/partially dependent upon earnings of the deceased insured person will also be necessary. If you are such a dependant, then in addition to Form 18, please also furnish a certificate of dependency in the form given at the bottom of enclosed form duly attested by one of the authorities mentioned in the foot-note of the enclosed form. A copy of form 18 is enclosed herewith.

It is further made clear to you that this invitation to submit claim form does not confer upon you any right to claim dependants' benefit under the E. S. I. Act. Your claim will be considered only when the death of the insured person referred to above has been established as due to employment injury, as defined under the Act.

Yours faithfully,

Regional Director

Copy to Branch Manager.....for information and with the request that the dependants may be guided properly in completing and submission of the documents, if they visit Branch Office.

Regional Director

**Form of Certificate of dependency
(To be submitted by dependant other than widow, son, daughter and widowed mother)**

Certified that I/we were wholly/partially dependent upon the earnings of the deceased Shri.....
Insurance No..... at the time of his death:

Sl.No.	Name	Father's/ Husband's Name	Relationship to deceased	Signature/ Thumb impression	Date
(1)	(2)	(3)	(4)	(5)	(6)
1.					
2.					
3.					

Certified that the above declaration is correct to my knowledge and belief.

Signature :

Designation :

Rubber stamp :

Note (i) In case of minor, signature/TI of guardian should be appended in Column (5)
(ii) This form may be got attested from any one of the following authorities:-

An officer of revenue, judicial or magisterial department of Government, or (ii) Municipal Commissioner or (iii) a Workmen's Compensation Commissioner or (iv) the head of gram panchayat under the official seal of the panchayat; or (v) a Member of Parliament; or (vi) a Member of Legislative Assembly; or (vii) a Member of Standing Committee or the Employees' State Insurance Corporation or (viii) a Member of Regional Board or Local Committee of the Corporation.

No.

Dated:

**BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION**

NOTICE

It has been reported to the Corporation that late Sri....., Insurance No..... employed in..... has died on..... as a result of employment injury. The matter is under consideration of the Regional Office, ESI Corporation to decide whether the death of the said insured person was due to employment injury or not. Pending decision of Regional Office in the matter, in order to avoid delay in settlement of the claims of dependants, I am directed to invite claims in the enclosed Form-15 from persons who claim to be the dependants of the deceased as per Section-2(6A) of the ESI Act as amended from time to time. Such claims should be supported by the evidence of dependency, age, etc. The conditions for claiming dependants' benefit are shown in annexure appended hereunder.

The claims should reach the undersigned within 30 days from the date of issue of this notice. This notice is issued without prejudice to the outcome to the case and the right of the Corporation to admit or reject the case on merits.

However, any action on these claims will be taken only if it is decided that the death was caused by employment injury.

Branch Manager
For Regional Director.

To

Copy to Regional Director, ESIC, _____

ANNEXURE

Regulation 80 of the E. S. I. (General) Regulations, 1950

Submission of claim for dependants' benefit:

- (1) A claim for dependants' benefit shall be submitted to the appropriate Branch Office by post or otherwise in Form 18 by the dependant or dependants concerned or by their legal representative or, in case of minor, by his guardian, and such claim shall be supported by documents proving –
 - (i) that the death is due to an employment injury;

- (ii) that the person claiming is a dependant entitled to claim as provided in Rule 58 of ESI (Central) Rules, 1950;
- (iii) the age of the claimant;
- (iv) the infirmity of the dependant claiming to be infirm within the purview of Rule 58 of the ESI (Central) Rules, 1950 by a certificate of such medical or other authority as the Director General may, by a general or special order specify in this behalf.

Provided that where the appropriate Regional Office is satisfied about the *bona fides* of the applicant or about the truth of the facts relating to any of the matters mentioned above, one or more of the documents may be dispensed with.

(2) The following may be accepted as proof of age –

- (a) certified extract from an official record of births showing the date and place of birth and father's name;
- (b) original horoscope prepared soon after birth;
- (c) certified extract from baptismal register;
- (d) certified extract from school records showing the date of birth and father's name;
- (e) such other evidence as may be acceptable to the appropriate Regional Office in the circumstances of a particular case.

Extract of Rule 58 (1) of ESI (Central) Rules, 1950

58. **Dependants' Benefit** (1) Dependants' benefit shall be paid to the dependants of the insured person who dies as a result of an employment injury, in the following manner:–

(A) In the case of death of the insured person, the dependants' benefit shall be payable to his widow, widowed mother and children as follows:–

- (a) to the widow during life or until remarriage, an amount equivalent to three-fifths of the full rate and, if there are two or more widows, the amount payable to the widows as aforesaid shall be divided equally between the widows;
- (b) to each legitimate or adopted son, an amount equivalent to two-fifths of the full rate until he attains the age of eighteen years:

PROVIDED that in the case of a legitimate or adopted son who is infirm and who is wholly dependent on the earnings of the insured person at the time of his death, dependants' benefit shall continue to be paid while the infirmity lasts;

- (c) to each legitimate or adopted unmarried daughter, an amount equivalent to two-fifths of the full rate until she attains the age of eighteen years or until marriage whichever is earlier :

PROVIDED that in the case of legitimate unmarried daughter who is infirm and is wholly dependent on the earnings of the insured person at the time of his death, dependants' benefit shall continue to be paid while the infirmity lasts and she continues to be unmarried:

PROVIDED FURTHER that if the total of the dependants' benefit distributed among the widow/widows and legitimate or adopted children and widow mother of the deceased person as aforesaid exceeds at any time the full rate, the share of each of the dependants shall be

proportionately reduced, so that the total amount payable to them does not exceed the amount of disablement benefit at the full rate.

d) To the widowed mother during life an amount equivalent to two-fifths of the full rate.

(B) In case the deceased person does not leave a widow or legitimate or adopted child, or widow mother, dependants' benefit shall be payable to other dependants as follows :

(a) to a parent other than widow mother or grandparent, for life, at an amount equivalent to three-tenths of the full rate and if there are two or more parents other than widow mother or grandparents, the amount payable to the parents other than widow mother or grandparents as aforesaid shall be equally divided between them.

(b) To any other –

(i) male dependant, until he attains the age of eighteen years;

(ii) female dependant, until she attains the age of eighteen years or until marriage, whichever is earlier or if widowed, until she attains eighteen years of age or remarriage, whichever is earlier,

at an amount equivalent to two-tenths of the full rate:

PROVIDED that if there be more than one dependant under clause (b), the amount payable under this clause shall be equally divided between them.

Annexure IIB
(See para P.6.16(e) & P.6.38)

**(Suggested) proforma for
CERTIFICATE OF INFIRMITY**

This is to certify that Shri/Km..... date of birth/agedS/d of late Sh./Smt..... (IP/IW), Ins. No..... has been examined by me today and that in my opinion he/she is/has continued to be infirm by reason of which he/she was wholly dependent on the earnings of his/her father/mother and in my opinion his/her infirmity prevents him/her from making a living.

Nature of infirmity

MEDICAL REFEREE
ESI Corpn.....

Dated:

Name:

Rubber Stamp:

**REGIONAL OFFICE/BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION**

.....

No.....

Date:.....

To

Shri/Smt/Kumari.....

.....

**Sub: Dependants' benefit claim under the Employees' State Insurance Act, 1948
in respect of late Ins. No**

Dear Sir/Madam,

It has been reported to the Corporation that you are the widow/the son/the daughter of late Shri/Smt.....who died on.....as a result of employment injury atI have, therefore, to draw your attention to the fact that under Rule 58 of the ESI (Central) Rules, 1950, the following persons are entitled to dependants' benefit :-

- 1. Widow/widows.
- *2. Legitimate or adopted son under 18 years of age.
- *3. Legitimate or adopted unmarried daughter under 18 years of age.
- *4. Legitimate or adopted son who is infirm and was wholly dependent on the earnings of the insured person at the time of his death, till the infirmity lasts.
- *5. Legitimate or adopted unmarried daughter who is infirm and was wholly dependent on the earnings of insured person at the time of his death till the infirmity lasts and she continues to be unmarried.

In case the deceased insured person leaves no surviving widow/child the following person can get dependants' benefit :-

- (a) A widowed mother
- (b) A dependent parent or grand parent other than a widowed mother.
- (c) Any other
 - (i) male dependant, until he attains eighteen years of age,
 - (ii) female dependant, until she attains eighteen years of age or until marriage whichever is earlier or, if widowed, until she attains eighteen years of age or remarriage.

If you are such a dependant, please complete the enclosed claim form and submit it to this office within 30 days of the receipt of this letter alongwith the necessary documents, as indicated on reverse.

Yours faithfully,

Regional Director

Encl: Claim form No. 15

* The age of son, daughter, male dependant and female dependant is to be determined on the day of death of the insured person.

DOCUMENTS REQUIRED

1. Proof of death, i. e., death certificate in original from Insurance Medical Officer/from the hospital or a copy of the post mortem report or municipal death certificate supported by the evidence that death was due to employment injury.
2. Proof of claimant's age where the claim is made under clause marked with an asterisk on the other side. Any one of the following documents may be accepted as proof of age:
 - (a) Certified extract from an official record of births showing the date and place of birth and father's name.
 - (b) Original horoscope prepared soon after birth.
 - (c) Certified extract from school records showing the date of birth and father's name.
 - (d) Certified extract from baptismal register.
 - (e) In case no such document in proof of age as mentioned above is available, this office may be informed accordingly.
3. A declaration stating that the widow and other female dependants have not married/remarried since the date of the deceased's death.
4. Name, age and address of each of the other persons surviving the deceased alongwith their relationship to him.

REGIONAL OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

To

.....
.....
.....

Sub: **Claim by the dependants of Late Shri/Smt./Kum.....**
Ins. No

Dear Sir/Madam,

I regret to inform you that your claim dated.....for dependants' benefit in connection with the death of the above insured person/woman has not been accepted for the reason indicated on the back of this card at No.....

Yours faithfully,

Regional Director

1. You are not a dependant of the deceased within the meaning of the term as defined in the ESI Act & the ESI (Central) Rules made thereunder.
2. You were more than 18 years of age at the time of the deceased's death.
3. You were married before the deceased's death.
4. Your infirmity is not supported by a medical certificate acceptable to the Corporation.
5. _____

From

The Regional Director,

To

Sub: Claim by the dependants of Late Shri/Smt./Kum.....

Ins. No

--	--

Dear Sir/Madam,

With reference to your claim datedI am glad to advise you that the same has been admitted. You will be entitled to dependants' benefit at Rs.....per day with effect from

..1. for life or until remarriage.

2. upto when you complete 18 years of age or until you marry, if earlier.

3. till your infirmity lasts.

I enclose a claim form (form 18A) on which you have to make a claim for the period from to The completed form may kindly be presented at our Branch Office at on any working day between..... and This payment has to be received personally.

Subsequent claims will have to be made for complete calendar months. The above named Branch Office will be sending you the necessary claim form every month for completion and return. You can elect to receive your subsequent payments by Money Order free of cost and you should avail of this facility unless you prefer to receive the benefit at the Branch Office counter.

Yours faithfully,

Regional Director
.....

Copy to Branch Office.

..* Score out parts not applicable

**CLAIM FOR PERIODICAL PAYMENTS OF DEPENDANTS' BENEFIT
EMPLOEES' STATE INSURANCE CORPORATION**

(Regulation 83-A)

Name of the deceased Insured Person _____ Insurance number No. _____

I _____ being the _____ of the above- named deceased
(relationship)
Insured Person, and also being his/her dependant, do hereby claim Dependant's Benefit for the period from
..... to

The amount due may be paid to me by money order
In cash/by cheque at Branch Office.

I also declare that –

- *I) I have not married/remarried so far
(Applicable only in case of a female dependant).
- *II) I have not attained the age of 18 years
(Applicable in case of a minor male/female dependant).
- *III) I am still infirm.
(Applicable only in case of a legitimate/ adopted* infirm son or a legitimate/adopted*
unmarried infirm daughter who has attained the 18 yrs. of age. The claim to be
accompanied, if required, by a certificate of specified authority).

Date

**Signature or thumb-impression of the claimant

Present address

.....

Or

***Signature/Thumb-impression of the Guardian

For _____

(Name of the minor Dependant)

Through _____

(name of the Guardian)

His/her _____

(relationship with the Minor)

* Please strikeout whichever is not applicable.

** Applicable in case of a claim by a major Dependant.

*** Applicable in the case of a claim for a minor dependant.

[Please refer to Rule 58 of the ESI (Central) Rules 1950]

DEPENDANTS' BENEFIT

1. Name of dependant _____	4. Name of guardian _____	7. (a) Identification mark of the dependant _____	8. Date of review _____
2. Date of birth _____	5. Date of commencement of benefit _____	(b) Dated initials of the Branch Manager _____	9. Date of termination of benefit (in case of minor) _____
3. Relationship to the deceased insured person _____	6. Rate of benefit _____		

Name of deceased insured person	Date	BENEFIT PAYABLE				INITIALS		BENEFIT PAYMENT					BENEFIT TERMINATED	Due date for next declaration	Remarks
		From day and month	To day and month	No. of days	Amount of benefit	Calculated by	Checked by	Passing day and month	Initials	Payment day and month	Schedule sheet No.	Sl. No.	How & date		
Insurance No.															
Employer's Code No.															
Date of employment injury															
Reference to the decision received from Regional Office															
Full rate of benefit															
Entered by															
Checked by															

FORM 24

(to be submitted along with claim for June & December)

DECLARATION & CERTIFICATE FOR DEPENDANTS' BENEFIT
EMPLOYEES STATE INSURANCE CORPORATION
(Regulation 107A)

Name of the deceased Insured Person _____ Ins. No. _____

I, _____, being the _____ of the above –named deceased Insured Person and also being his dependant, do hereby solemnly declare:-

- *i) that I have not married/remarried so far.
(to be given only by a female dependant)
- *ii) that I have not yet attained the age of eighteen years.
(to be given only in respect of a minor male or female dependant)
- *iii) that I have attained the age of eighteen years but continue to be infirm.
(to be given by a legitimate/adopted infirm son or by a legitimate/adopted infirm daughter. Certificate as specified, to be attached, if required)

Present Address: _____

Date.....

Signature or thumb impression
of the dependant

or

Name in Block letters
of signing claimant.

Signature or thumb impression of the
Guardian in case of a minor dependant

Name of the Minor _____
Through _____
(name of the Guardian)
His/her _____
(relationship with the Minor)

CERTIFICATE

** Certified that Shri/ Smt. Kumari _____ w/s/d/ of _____ is alive this day the _____ day of _____ 20 _____ and that the declarations made above are true to the best of my knowledge and belief.

Date _____

Name in Block letter and
Rubber Stamp or Seal of the
Attesting Authority

Signature _____
Designation _____

- Strike out whichever is not applicable.

** This certificate is to be given by (i) an officer of the Revenue, Judicial or Magisterial Department, or (ii) a Municipal Commissioner, or (iii) a Workmen's Compensation Commissioner, or (iv) the Head of gram Panchayat under the official seal of the Panchayat, or (v) an M.L.A./M.P.; or (vi) A Gazetted officer of the Central / state Govt. or (vii) a member of the Regional Board/Local Committee of the ESIC; or (viii) any other authority considered appropriate by the Branch Manager concerned.

IMPORTANT: Any person who makes a false statement or misrepresentation for the purpose of obtaining benefit, whether for himself or some other person, commits an offence punishable with imprisonment for a term which, may extend up to six months or with a fine up to Rs.2,000/- or with both.

(See para P.6.40)

(BY REGISTERED POST)

**REGIONAL OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION**

No.....

Dated:.....

To

**Sub: Review of dependants' benefit in respect of late.....
 in terms of Section 55A of the ESI Act, 1948**

Dear Sir/Madam,

Kindly take notice that the Corporation has taken in hand the review of rates of dependants' benefit admissible to the dependants of the above-named deceased insured person. As a result, the existing rate of dependants' benefit may be got reduced/enhanced/stopped.

For this, if you have any objection to the proposed review, you are advised to file the same within 21 days of the issue of this letter. Please note that if no reply is received by....., it would be presumed that you have no objection for such review, and the matter will be dealt with as proposed above.

Yours faithfully,

Regional Director

Copy forwarded to the Manager, Branch Officefor information. He is requested to forward the objections, if any, submitted by any of the dependants of the deceased as early as possible. He is also advised to stop the payment of dependants' benefit with effect from.....

For Regional Director

Annexure X
(See para P.6.41)

(BY REGISTERED POST)

REGIONAL OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

No.....

Dated:.....

To
Shri/Smt. _____

Sub: **Review of dependants' benefit in respect of late.....**

Dear Sir/Madam,

In continuation of this office letter of even number dated on the subject noted above, I have to inform you that as a result of the review of dependants' benefit, the Corporation has decided to commence/continue/increase/reduce/discontinue the share of each person mentioned below :-

Name of Person	Relationship to deceased insured person	New rate of benefit	Date from which payable

Shri/Smt your father/mother has been accepted as your guardian and he/she would receive payment of dependants' benefit on your behalf from the Branch Office.

Yours faithfully,

Regional Director

Copy forwarded to the Manager Branch Office for information and necessary action. The date of birth of Shri/Smt./Kumari has been accepted as.....

CHAPTER VII
SICKNESS BENEFIT LAW
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CHAPTER VII

SICKNESS BENEFIT LAW

Characteristics of sickness benefit

L.7.1. Sickness Benefit represents periodical payments to an insured person in case of his sickness certified by a duly appointed medical officer/practitioner [Sec.46(1)(a)]. These payments are subject to the conditions laid down in ESI Act, 1948, the ESI (Central) Rules, 1950 and the ESI (General) Regulations, 1950. A few characteristics of sickness benefit are given below :

- (1) It consists of periodical payments.
- (2) It is payable to an 'insured person'. An insured person is one who is or was an employee, in respect of whom contributions are or were payable and who is, by reason thereof, entitled to any of the benefits provided by the Act.
- (3) It is payable for sickness which has been defined in clause (20) of Section 2 of the Act as "a condition which requires medical treatment and attendance and necessitates abstention from work on medical grounds". The term 'necessitates abstention from work' implies that an attempt to work is likely to be prejudicial to the health of the insured person. Further, a condition which requires medical treatment and attendance alone but not abstention from work on medical grounds, and a condition which necessitates abstention from work on medical grounds but does not require medical treatment and attendance is not deemed "sickness" and sickness benefit is not payable. In other words, sickness benefit is payable to an insured person whose condition requires both (i) medical treatment and attendance and also (ii) necessitates abstention from work.
- (4) Sickness, as defined above, must be certified by a duly appointed medical practitioner. Under the ESI (General) Regulations, the Insurance Medical Officer is the duly appointed medical practitioner. (For details regarding medical certification, see Chapter II-Certification).
- (5) It is subject to fulfilment of contributory conditions as per details in subsequent paragraphs.

Certification for sickness

L.7.2. As per Regulation 53, an insured person who desires to claim sickness benefit should submit, alongwith his claim, a certificate from a duly appointed medical practitioner or by any other person possessing such qualifications and experience as the Corporation may by Regulations specify in this behalf. The certificate should be in the appropriate form covering the period for which he desires to claim sickness benefit. Proviso to Regulation 53 also provides that in any area where arrangements for medical benefit under the ESI Act have not been made or otherwise if in its opinion the circumstances of a particular case so justify, the Corporation may accept any other evidence of sickness or temporary disablement in the form of a certificate issued by the medical officer of the State Government, local body or other medical institution, or a certificate issued by any registered medical practitioner containing such particulars and attested in such a manner as may be specified by the Director General in this behalf. (For detailed instructions refer to Chapter II-Certification).

Qualifying condition for sickness benefit

L.7.3. Central Rule 55(1), as amended w.e.f. 19.09.1998, states as under:

55(1) Subject to the provisions of the Act and the regulations, a person shall be qualified to claim sickness benefit for sickness occurring during any benefit period if the contributions in respect of

him were payable for not less than 78 days of the corresponding contribution period and shall be entitled to receive such benefit at the daily standard benefit rate for the period of his sickness.

L.7.4. A proviso added to the Sub-Rule 55(1) w.e.f. 08.04.2000, states as under :

Provided that in case of a person who becomes an employee within the meaning of the Act for the first time and for whom a shorter contribution period of less than 156 days is available, he shall be qualified to claim sickness benefit if the contributions in respect of him were payable for not less than half the number of days available for working in such contribution period.

Thus, the condition of 78 days' contribution as given in Rule55(1) has been relaxed to half the number of days which would work out to less than 78 days for a new entrant who becomes an employee when less than 156 days are left in a contribution period. Those new entrants who join (1) on or after 28th April in a contribution period ended 30th September, or (2) on or after 27th October in a contribution period ended 31st March of a normal year and (3) on or after 28th October in a contribution period ended 31st March of a leap year, will be benefitted by this proviso and can avail of sickness benefit in their relevant benefit periods.

Contribution and benefit periods

L.7.5. Clause (1C) and (2A) of Central Rule 2 define respectively the benefit period and contribution period as under (with effect from 1.2.1991) :-

(1C) 'benefit period' means the period not exceeding six consecutive months corresponding to the contribution period, as may be specified in the regulations.

(2A) 'contribution period' means such period not exceeding six consecutive months as may be specified in the regulations.

L.7.6. As per Regulation 4, contribution periods and the corresponding benefit periods shall be as under:

Contribution period	Corresponding benefit period
1 st April to 30 th September	1 st January of the year following to 30 th June
1 st October to 31 st March of the year following	1 st July to 31 st December

L.7.7. In case of a new entrant, the said Regulation 4 provides that his first contribution period will commence from the date he becomes an employee under the Act and his corresponding benefit period will begin exactly 9 months later. The dates of ending of both contribution and benefit periods will remain the same as in the case of old entrants. Thus every new entrant will automatically fit into the contribution period current at the time of his entry and he will have his first benefit period started from the same date exactly nine months later. The second and subsequent contribution periods in respect of this entrant as also his corresponding benefit periods will be determined in accordance with the dates mentioned in the preceding paragraph.

L.7.8. A few illustrations of first contribution period of a new entrant and his corresponding benefit period are added below :-

Date of entry	First Contribution Period		First Benefit Period	
	From	To	From	To
01/11/06	01/11/06	31/03/07	01/08/07	31/12/07
31/12/06	31/12/06	31/03/07	30/09/07	31/12/07
28/02/07	28/02/07	31/03/07	28/11/07	31/12/07
29/05/06	29/05/06	30/09/06	01/03/07	30/06/07
29/05/07	29/05/07	30/09/07	29/02/08	30/06/08

Standard benefit rate:

L.7.9. Central Rule 54 prescribes the daily standard benefit rates for employees falling in each of the wage groups given in the table below which took effect from 19.09.1998 and which was updated with the addition of higher wage groups, first w.e.f. 01.04.2004 when the wage limit for coverage of employees was raised to Rs.7,500/- per month and again w.e.f. 01.10.2006 when it was raised to Rs.10,000/- per month. This was further updated w.e.f. 01.04.2008 when disabled insured persons were also brought under coverage of the scheme subject to conditions.

TABLE

Group of employees whose average daily wages are		Standard benefit rate (in Rs.)	
1.	Below Rs. 6	....	2.50
2.	Rs. 6 and above but below Rs. 8	....	3.50
3.	Rs. 8 and above but below Rs. 12	....	5.00
4.	Rs. 12 and above but below Rs. 16	....	7.00
5.	Rs. 16 and above but below Rs. 24	....	10.00
6.	Rs. 24 and above but below Rs. 36	....	15.00
7.	Rs. 36 and above but below Rs. 48	....	20.00
8.	Rs. 48 and above but below Rs. 64	....	28.00
9.	Rs. 64 and above but below Rs. 80	....	36.00
10.	Rs. 80 and above but below Rs. 96	....	44.00
11.	Rs. 96 and above but below Rs. 116	....	53.00
<i>(With effect from 1.1.97)</i>			
12.	Rs. 116 and above but below Rs. 136	....	63.00
13.	Rs. 136 and above but below Rs. 156	....	73.00
14.	Rs. 156 and above but below Rs. 176	....	83.00
15.	Rs. 176 and above but below Rs. 196	....	93.00
16.	Rs. 196 and above but below Rs. 216	....	103.00
17.	Rs. 216 and above but below Rs. 236	....	113.00

18.	Rs. 236 and above	125.00
-----	-------------------	------	------	--------

The above table with the first 11 items, remained in force for so long as the monthly wage limit for coverage was Rs. 3000/-, i. e., upto 31.12.1996. With effect from 1.1.1997, monthly wage limit for coverage was raised to Rs. 6,500/- and items at Serial Nos. 12 to 18 were added so as to cover the higher wage groups. The above table was again replaced by a new table as given below w. e. f. 19.9.1998:

TABLE

	<i>Group of employees whose average daily wages are</i>			<i>Standard benefit rate (in Rs.)</i>
1.	Below Rs. 28	....		14 or full average daily wage whichever is less
2.	Rs. 28 and above but below Rs. 32	....	....	16
3.	Rs. 32 and above but below Rs. 36	....	....	18
4.	Rs. 36 and above but below Rs. 40	....	....	20
5.	Rs. 40 and above but below Rs. 48	....	....	24
6.	Rs. 48 and above but below Rs. 56	....	....	28
7.	Rs. 56 and above but below Rs. 60	....	....	30
8.	Rs. 60 and above but below Rs. 64	....	....	32
9.	Rs. 64 and above but below Rs. 72	....	....	36
10.	Rs. 72 and above but below Rs. 76	....	....	38
11.	Rs. 76 and above but below Rs. 80	....	....	40
12.	Rs. 80 and above but below Rs. 88	....	....	44
13.	Rs. 88 and above but below Rs. 96	....	....	48
14.	Rs. 96 and above but below Rs. 106	....	....	53
15.	Rs. 106 and above but below Rs. 116	....	....	58
16.	Rs. 116 and above but below Rs. 126	....	....	63
17.	Rs. 126 and above but below Rs. 136	....	....	68
18.	Rs. 136 and above but below Rs. 146	....	....	73
19.	Rs. 146 and above but below Rs. 156	....	....	78
20.	Rs. 156 and above but below Rs. 166	....	....	83
21.	Rs. 166 and above but below Rs. 176	....	....	88
22.	Rs. 176 and above but below Rs. 186	....	....	93
23.	Rs. 186 and above but below Rs. 196	....	....	98
24.	Rs. 196 and above but below Rs. 206	....	....	103
25.	Rs. 206 and above but below Rs. 216	....	....	108
26.	Rs. 216 and above but below Rs. 226	....	....	113
27.	Rs. 226 and above but below Rs. 236	....	....	118
(With effect from 01.04.2004) when wage limit for coverage was raised to Rs.7,500/-)				
28.	Rs. 236 and above but below Rs.250	....	....	125

29.	Rs. 250 and above but below Rs.260	....	....	130
30.	Rs. 260 and above but below Rs.270	....	....	135
31.	Rs. 270 and above but below Rs.280	....	....	140

(With effect from 1.10.2006) when wage limit for coverage was raised to Rs.10,000/-)

32.	Rs. 280 and above but below Rs.290	....	....	145
33.	Rs. 290 and above but below Rs.300	....	....	150
34.	Rs. 300 and above but below Rs.310	....	....	155
35.	Rs. 310 and above but below Rs.320	....	....	160
36.	Rs. 320 and above but below Rs.330	....	....	165
37.	Rs. 330 and above but below Rs.340	....	....	170
38.	Rs. 340 and above but below Rs.350	....	....	175
39.	Rs. 350 and above but below Rs.360	....	....	180
40.	Rs. 360 and above but below Rs.370	....	....	185
41.	Rs. 370 and above but below Rs.380	....	....	190

(The following rates are effective from 1.4.2008 in respect of Disabled Insured Persons only)

42.	Rs. 380 and above but below Rs.390	....	....	195
43.	Rs. 390 and above but below Rs.400	....	....	200
44.	Rs. 400 and above but below Rs.410	....	....	205
45.	Rs. 410 and above but below Rs.420	....	....	210
46.	Rs. 420 and above but below Rs.430	....	....	215
47.	Rs. 430 and above but below Rs.440	....	....	220
48.	Rs. 440 and above but below Rs.450	....	....	225
49.	Rs. 450 and above but below Rs.460	....	....	230
50.	Rs. 460 and above but below Rs.470	....	....	235
51.	Rs. 470 and above but below Rs.480	....	....	240
52.	Rs. 480 and above but below Rs.490	....	....	245
53.	Rs. 490 and above but below Rs.500	....	....	250
54.	Rs. 500 and above but below Rs.510	....	....	255
55.	Rs. 510 and above but below Rs.520	....	....	260
56.	Rs. 520 and above but below Rs.530	....	....	265
57.	Rs. 530 and above but below Rs.540	....	....	270
58.	Rs. 540 and above but below Rs.550	....	....	275
59.	Rs. 550 and above but below Rs.560	....	....	280
60.	Rs. 560 and above but below Rs.570	....	....	285
61.	Rs. 570 and above but below Rs.580	....	....	290
62.	Rs. 580 and above but below Rs.590	....	....	295

63	Rs. 590 and above but below Rs.600	....	....	300
64	Rs. 600 and above but below Rs.610	....	....	305
65	Rs. 610 and above but below Rs.620	....	....	310
66	Rs. 620 and above but below Rs.630	....	....	315
67	Rs. 630 and above but below Rs.640	....	....	320
68	Rs. 640 and above but below Rs.650	....	....	325
69	Rs. 650 and above but below Rs.660	....	....	330
70	Rs. 660 and above but below Rs.670	....	....	335
71	Rs. 670 and above but below Rs.680	....	....	340
72	Rs. 680 and above but below Rs.690	....	....	345
73	Rs. 690 and above but below Rs.700	....	....	350
74	Rs. 700 and above but below Rs.710	....	....	355
75	Rs. 710 and above but below Rs.720	....	....	360
76	Rs. 720 and above but below Rs.730	....	....	365
77	Rs. 730 and above but below Rs.740	....	....	370
78	Rs. 740 and above but below Rs.750	....	....	375
79	Rs. 750 and above but below Rs.760	....	....	380
80	Rs. 760 and above but below Rs.770	....	....	385
81	Rs. 770 and above but below Rs.780	....	....	390
82	Rs. 780 and above but below Rs.790	....	....	395
83	Rs. 790 and above but below Rs.800	....	....	400
84	Rs. 800 and above but below Rs.810	....	....	405
85	Rs. 810 and above but below Rs.820	....	....	410
86	Rs. 820 and above but below Rs.830	....	....	415
87	Rs. 830 and above but below Rs.840	....	....	420
88	Rs. 840 and above but below Rs.850	....	....	425
89	Rs. 850 and above but below Rs.860	....	....	430
90	Rs. 860 and above but below Rs.870	....	....	435
91	Rs. 870 and above but below Rs.880	....	....	440
92	Rs. 880 and above but below Rs.890	....	....	445
93	Rs. 890 and above but below Rs.900	....	....	450
94	Rs. 900 and above but below Rs.910	....	....	455
95	Rs. 910 and above but below Rs.920	....	....	460
96	Rs. 920 and above but below Rs.930	....	....	465
97	Rs. 930 and above but below Rs.940	....	....	470
98	Rs. 940 and above but below Rs.950	....	....	475

Sickness benefit rate:

L.7.10. W.e.f. 01.12.2007, the daily sickness benefit rate shall be 20% more than the standard benefit rate. Prior to this date, the daily sickness benefit rate was the same as the standard benefit rate described in the preceeding paragraph.

Average daily wages

L.7.10A. Clause (1A) of Central Rule 2 defines 'Average daily wages during a contribution period', in respect of an employee for the purpose of daily rates of sickness benefit, maternity benefit, disablement benefit and dependants' benefits is the sum equal to 115% of the aggregate amount of wages payable to him during that period, divided by the number of days (including paid holidays and leave days) for which such wages were payable.

Reduced to arithmetical formula:

$$\text{Average daily wages} = \frac{\text{Total wages paid/payable during a contribution period}}{\text{No. of days for which wages paid/payable}} \times \frac{115}{100}$$

The result arrived at is fitted into the table in Para L.7.9 and daily rate of standard benefit, i. e., the daily rate of sickness benefit is determined. However, to facilitate Branch Office staff in calculating easily the standard benefit rate, a ready reckoner has been supplied in enough copies with the help of which they can directly arrive at the figure of daily standard benefit rate by fitting the total wages paid/payable to an IP in a contribution period with reference to the number of days for which these wages were paid/payable. Qualifying condition for sickness benefit (paras L.7.3. and L.7.4 *supra*) must also be satisfied for eligibility to sickness benefits.

Waiting days and total days

L.7.11. Provisos below Sub-rule (1) of Central Rule 55 say as under :-

Provided that he shall not be entitled to the benefit for the first two days of sickness except in the case of a spell of sickness following, at an interval of not more than 15 days, the spell of sickness for which sickness benefit was last paid;

Provided further that sickness benefit shall not be paid to any person for more than 91 days in any two consecutive benefit periods.

Waiting days explained

L.7.12. As regards the first proviso under Central Rule 55(1), an insured person is not ordinarily entitled to sickness benefit for an initial period of two days in the spell of sickness. However, if the spell of sickness follows another spell of sickness for which this benefit was last paid, at an interval of not more than 15 days, there will be no waiting period in the second spell. As an illustration, where the first spell of sickness is, say, from 10th September to 27th September and the second spell is from 13th October to 18th October, then since the interval between the two spells is only 15 clear days, there will be no waiting period in the second spell if the insured person had been paid sickness benefit for the whole or part of the first spell of sickness. However, if the second spell of sickness had commenced from 14th October, the interval between the two spells of sickness would exceed 15 days and, in that case, no benefit would be admissible for 14th and 15th October.

L.7.13. A few illustrations are added to make the point clear:-

- (i) An insured person who had already been paid sickness benefit for 84 days during the current benefit period, submitted certificates of sickness for the period from, say, 1.6.08 to 30.6.08 and he was paid sickness benefit for seven days only as under :-

1.6.08 to 2.6.08	:	Waiting days
3.6.08 to 9.6.08	:	Benefit days
10.6.08 to 30.6.08	:	No benefit paid, 91 days being exhausted

The insured person having become eligible in the next benefit period commencing 1.7.08, no waiting days would be deducted if his second spell of sickness commenced on or before 16.7.08

- (ii) In the above example, if the insured person had not been paid sickness benefit for any day in the entire spell of sickness 1.6.08 to 30.6.08, he having exhausted it, waiting days would be deducted even if the next spell of sickness commenced on or before 16.7.08.

- (iii) An insured person submits medical certificates for the first time, covering spells of sickness lasting two days at a time and occurring within a single fortnight as under, followed by a spell of sickness lasting say, 3 days, as under :

1 st Spell	:	4 th and 5 th May
2 nd Spell	:	10 th and 11 th May
3 rd Spell	:	18 th to 20 th May

In the above case, sickness benefit will be admissible for 20th May, i. e., for one day only.

L.7.14. It may further be clarified that where spell of sickness commences before the beginning of a benefit period and continues into the benefit period, the days of the spell occurring before the benefit period will be counted as waiting days even though the insured person may not be qualified to claim sickness benefit before the commencement of the benefit period in which the spell terminates. Such a case may arise where:

- the spell of sickness of a new entrant commences before, but ends during his first benefit period, or
- the spell of sickness commences in a benefit period in which the insured person is not qualified to claim sickness benefit but ends in the benefit period in which he is so qualified, or
- the spell of sickness commences in the benefit period after the IP has exhausted his sickness benefit in an earlier spell and the present spell continues into the benefit period in which he again becomes entitled to sickness benefit

L.7.15.1. Once waiting days have been deducted from the spell of his sickness, his sickness benefit for the next spell following at an interval not exceeding 15 days from the last day of the earlier spell, will be payable from the first day of the second spell, which also includes a spell of one or two days

only. Again, if the third spell falls similarly within 15 days of the second spell, even if for a day only, sickness benefit will be payable even for that single day, and so on.

L.7.15.2. The period of 15 days intervening between two spells will exclude the last day of the previous spell and also the first day of the present spell. For example, if previous spell terminated on 31st January, the second spell if starting on 16th February or earlier will entitle the insured person to receive sickness benefit from the 16th February itself, if found admissible.

L.7.16. Sickness as defined in Section 2(20) means a condition which requires medical treatment and attendance and necessitates abstention from work on medical grounds. As such, the waiting period of two days will count from the day insured person abstains from work on medical grounds and requires medical treatment and attendance on the said days and not merely from the first two days of certified sickness. As an illustration, if an insured person falls sick after working for part or whole of a day for which he has received wages, in part or in full, that day will not be counted for the purpose of initial waiting period of two days even if medical certificate is issued to cover that day.

L.7.17. As will be clear from the foregoing paragraph, for a period of 2 days to be counted as waiting days, an IP must have not only been certified sick (by issue of first certificate), but he should also have abstained from work for a continuous period of the first two days of the spell and should also have continued thereafter to abstain from work as directed by his treating IMO; otherwise he may lose benefit for more than two days; The following illustrations will make this point clear:

Illustration 1: An IP produced a certificate of sickness from 1.5.08 to 15.5.08. If found eligible, he should have been normally paid sickness benefit for 13 days, from 3.5.08 to 15.5.08. But in his claim, he stated that he worked in the factory on 2.5.08 and 4.5.08. In his case, the waiting days would be 5th and 6th May 2008 and he would receive sickness benefit for 9 days from 7th May to 15th May, 08.

Illustration 2: If the above-named IP had declared to have abstained from work on 1st and 2nd May 08, worked on 3rd and 4th May and then abstained from 5.5.08 to 15.5.08 he would again receive sickness benefit for 9 days from 7th May to 15th May 08.

L.7.18. When an insured person starts work at zero hour e. g. say midnight between 26th and 27th March and works throughout the shift ending at 8 A. M. on 27th March, and he falls sick immediately after work for which he is issued medical certificate by his IMO/IMP, waiting period will be the 27th and 28th March or the 28th and 29th March, depending on whether he is marked present by the employer for the third shift of 26th or first shift of 27th March.

No payment for strike period etc.

L.7.19. Section 63 of the ESI Act as amended with effect from 20-10-1989, states that “save as may be provided in the regulations, no person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he works or remains on leave or on a holiday in respect of which he receives wages or on any day on which remains on strike”.

Under this Section, no sickness benefit is payable for a paid leave day or a paid holiday falling during the period of a certified sickness. Similarly, no sickness benefit is normally payable, if the period of certified sickness happens to fall during the period of strike, except in the following circumstances as provided in Regulation 99A during which, despite the strike, sickness benefit is admissible for payment:

- (1) If IP is receiving medical treatment and attendance as an indoor patient in the ESI Hospital or in a hospital recognised by the Corporation for such treatment.
- (2) If he is in receipt of sickness benefit immediately preceding the date of commencement of notice of strike given by the employees’ union(s) to the management of the factory/ establishment.

Paid holidays etc. as waiting days

L.7.19A. The days of paid leave/paid holiday for which sickness benefit is not payable under Section 63 would, however, be taken into account for reckoning the waiting period of the first two days of the spell of sickness because the insured person is certified as needing both (i) medical treatment and attendance and (ii) abstention from work on medical grounds and since he did not work, he satisfies both these conditions.

Conditions to be observed for sickness benefit

L.7.20. A claimant for sickness benefit has to satisfy the following conditions :-

- (i) He must not work for wages during the period for which he claims sickness benefit.
- (ii) He must submit a claim in the manner and within the time-limits prescribed in the Regulations.
- (iii) He must observe certain rules of behaviour regarding medical treatment, care of health, etc., during the period for which he claims benefit (for details refer to paras 2.33 to 2.36.2 of chapter II – Certification on the subject).

When claim becomes due

L.7.21. A claim for sickness benefit for any period becomes due on the date of issue of the medical certificate in respect of such period provided that in cases where a person is not entitled to sickness benefit for the first two days of sickness, the due date shall be deferred by such days (Reg. 45).

When claim is payable

L.7.22. Sickness benefit is payable not later than 7 days after the claim therefor together with the relevant medical or other certificates and any other documentary evidence which may be called for under the regulations has been furnished (complete in all particulars) to the appropriate Branch Office (Reg. 52).

Submission of claim for benefit

L.7.23. An insured person intending to claim sickness benefit has to submit to the appropriate Branch Office, by post or otherwise, a claim for benefit in form 9, retaining therein, the alternative appropriate to the circumstances of the case together with the appropriate medical certificate(s) (For details refer to instructions on General Claim Law and Procedure).

Bar on benefit to convicted insured person

L.7.24. Please see paras L.3.39 and L.3.40 of Chapter III – General Claims Law in this connection

Employer's liability for excessive sickness benefit

L.7.25. Under Section 69 of the Act:

- (1) Where the Corporation considers that the incidence of sickness among insured persons is excessive by reasons of –

- (i) insanitary working conditions in a factory or establishment or the neglect of the owner or occupier of the factory or establishment to observe any health regulations enjoined on him by or under any enactment, or
 - (ii) insanitary conditions of any tenements or lodgings occupied by insured persons and such insanitary conditions are attributable to the neglect of the owner of the tenements or lodgings to observe any health regulations enjoined on him by or under any enactment, the Corporation may send to the owner or occupier of the factory or establishment or to the owner of the tenements or lodgings, as the case may be, a claim for the payment of the amount of the extra expenditure incurred by the Corporation as sickness benefit; and if the claim is not settled by agreement, the Corporation may refer the matter, with a statement in support of its claim, to the appropriate Government.
- (2) If the appropriate Government is of the opinion that a prima-facie case for inquiry is made, it may appoint a competent person or persons to hold an inquiry into the matter.
 - (3) If upon such inquiry it is proved to the satisfaction of the person or persons holding the inquiry that the excess in incidence of sickness among the insured persons is due to the default or neglect of the owner or occupier of the factory or establishment or the owner of the tenements or lodgings, as the case may be, the said person or persons shall determine the amount of the extra expenditure incurred as sickness benefit, and the person or persons by whom the whole or any part of such amount shall be paid to the Corporation.
 - (4) A determination under sub-section (3) may be enforced as if it were a decree for payment of money passed in a suit by a Civil Court.
 - (5) The owner of tenements or lodgings shall include any agent of the owner and any person who is entitled to collect the rent of the tenements or lodgings as a lessee of the owner.

State Government to share excessive sickness benefit cost

L.7.26. Under Section 58(2) of the Act, where the incidence of sickness benefit payment to insured persons in any state is found to exceed the all-India average, the amount of such excess is to be shared between the Corporation and the State Government in such proportion as may be fixed by agreement between them, provided that the Corporation may in any case waive the recovery of the whole or any part of the share which has to be borne by the State Government.

CHAPTER VII

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CHAPTER VII

SICKNESS BENEFIT PROCEDURE

Claim for sickness benefit

P.7.1. A claim for sickness benefit can be made only on the basis of medical certificates issued by the doctors appointed for this purpose under the Scheme. However, the Corporation may accept any other evidence of sickness or temporary disablement if in its opinion the circumstances of any particular case so justify. The certificates issued by the Insurance Medical Officers are the first, the intermediate, the special intermediate and the final certificates. The claim form for benefit is printed just below each certificate.

P.7.2. An insured person may, if he so desires, deposit the certificates in the box, if any, provided for the purpose at the dispensary or the Branch Office to which he is attached or he may send them by post or may present them in the Branch Office in person, or may deliver the same at the Branch Office through his agent or messenger, within the period stipulated in Reg. 64 of ESI(Genl.) Regulation, 1950, i.e. within 3 days of its issue.

P.7.3. All certificates received should be examined in the first instance by the claims clerk or receptionist, if any, and defects, if any, should be got removed as indicated in relevant paras of the General Claims Procedure.

P.7.4. Where the receptionist, or any other member of the staff at the Branch Office finds at any stage that the certificate(s) has/have been tampered with in order to entitle an insured person to any benefit which is not otherwise admissible to him for part or whole of the period covered by the certificate(s), immediate report should be made to the Manager and action taken as per paras 11.62.1 to 11.69 of Chapter XI.

P.7.5. In case an insured person presents a certificate without an insurance number, it can be due to any of the following reasons :-

- (i) He may not have been allotted an insurance number because of his having entered insurable employment only recently. The certificate might have been issued on the basis of the certificate of employment in form ESIC-86.

OR

- (ii) In spite of his being in employment for a long time the declaration form was not filled in for him or the same was not submitted by the employer to the Regional/Branch Office; or the allotment of insurance number could not be made by the Regional Office/Branch Office for some reason.

P.7.6. In the first case above, the person will not be eligible for sickness benefit. All such certificates are to be kept in a folder arranged according to the names of insured persons in alphabetical order. The subsequent certificates received for the same spell will be filed along with their first certificates. Such certificates may not be required for long unless these relate to employment injury or are for a continuous spell which is partly for a period prior to commencement of his first benefit period and partly thereafter. Certificates of the letter type may be preserved for a year and weeded out thereafter.

P.7.7. In the second case of para P.7.5., where the first benefit period has started, the insured person will be asked to ascertain from the employer his insurance number or his serial number on the return of declaration forms and the date when it was sent to the Regional Office/Branch Office, the date of his entry in employment, and whether his contributory record was sent to the Regional Office or not. On receipt of the above information, if it is confirmed that the insured person is an old employee eligible to claim sickness benefit, a ledger sheet will be obtained from the Regional Office in case of centralised registration or opened at the Branch Office in case of decentralised registration in accordance with the

existing procedure. He will also be directed to obtain his identity card as well as contributory particulars in ESIC-71 (if needed) from the employer, and further action will be taken to pay him sickness benefit if he is found eligible for the same.

Where ledger-sheet is not available

P.7.8. Where documents in respect of the insured person have not been prepared or are not available at the Branch Office, it may be because –

- (i) the insured person entered insurable employment only recently; or
- (ii) he belongs to another Branch Office; or
- (iii) preparation of documents has been delayed at the Regional Office/Branch Office.

P.7.9. In the first case, as already explained, the insured person will not be eligible to sickness benefit and the certificates may be filed as explained in para P.7.6 and insured person will be informed about it. No regret slip need be issued in this case unless insisted upon.

P.7.10. Where a certificate belonging to another Branch Office is received and the exact Branch Office of the insured person is not known, the procedure to be followed will be as under :-

- (i) In a place where there are more than 2 Branch Offices and Regional Office is situated in another town, the name of Branch Office should be ascertained from the Regional Office and, on receipt of a reply, the certificate(s) should be sent to that Branch Office.
- (ii) In a place having more than 2 Branch Offices as also Regional Office, certificates should be sent to the Regional Office, from where they will be sent to the appropriate Branch Office. Where necessary, appropriate Branch Office may be ascertained on telephone and certificates sent directly to that Branch Office to avoid delay.
- (iii) In a place having 2 Branch Offices, certificates not belonging to one Branch Office will be sent to the other Branch Office.

Before a certificate is forwarded to another Branch Office, it should be duly diarised in the Branch Office on the date of receipt.

P.7.11. With a view to ensuring transmission of medical certificates to the correct Branch Office, the insured persons may be advised to write the name of their Branch Office prominently at the top of the claim form. The IMO/IMP could also be requested to indicate the insured person's Branch Office on the top of the certificate.

P.7.12. In case of centralised registration, where ledger sheet has not been received from Regional Office, priority reference should be made to the Regional Office on receipt of the first certificate for the spell during which the insured person is entitled for sickness benefit.

Missing ledger-sheet

P.7.13. Please see para P.3.9 of Chapter III-General Claims Procedure.

P.7.14. Payments on duplicate ledger-sheets should never be treated as a routine affair and it will be the personal responsibility of Branch Manager to satisfy himself as to the genuineness of the claim before making payment on a duplicate ledger-sheet.

P.7.15. Further, no slip whatsoever should be pasted under any circumstances on any entry of ledger-sheet and also no payment should be made on the basis of the pasted entry.

Precaution in case of first benefit period

P.7.16. It has to be ensured in respect of a new entrant that payment of sickness benefit is not started before the commencement of his first benefit period. For this, the ledger sheet should not be opened after the start of his benefit period in respect of the IP if he does not satisfy the contributory condition for payment of Sickness Benefit. It may, however, be opened if it becomes necessary to do so for other reasons (e. g., payment of employment injury benefit) in which case an entry in red ink “SB payment not to start before.....” should be made on the ledger sheet just above the record of cash benefits paid.

P.7.17. If any subsequent certificate has been received by post or cleared from the box or is sent by other Branch Office or by the Regional Office, the claims clerk will diarise the certificates in the claims diary and place it in insurance number order in the bundle of pending certificates.

P.7.18. If the subsequent certificate is received through messenger or by post or is cleared from the box or is sent by another Branch Office, and the claim form is duly completed and accompanied by a written request that payment be made by money order, the receptionist, if any, will send the certificate to the claims clerk who will diarise the claim and will take action thereon as explained in General Claims Procedure for remitting the amount of sickness benefit due by money order.

P.7.19. Intimation to an insured person in form ESIC-34 need not be issued at centres where the benefit provisions have been in operation for at least three years, which period is considered sufficient for the insured persons to get acquainted with their rights and obligations under the Scheme.

Old certificates

P.7.20. Please see para P.3.39 of Chapter III – General Claims Procedure.

P.7.21. Where no further certificate has been received after the receipt of first or intermediate certificate, or where the claim is not received, a letter in form ESIC-55 will be issued to the insured person. This is necessary only in the early stages of implementation of the Scheme in an area. As in case of ESIC-34, the drill of issue of form ESIC-55 need not be observed in respect of centres where benefit provisions of the Scheme have been in operation for at least three years.

Action by receptionist/claims clerk when insured person calls

P.7.22. Detailed procedure on action to be taken by the receptionist and/or claims clerk when an insured person calls at the Branch Office, such as his identification, filling up of claims etc., has been laid down in the General Claims Procedure. Specifics in respect of claims for sickness benefit are stated in paras given below which will *mutatis mutandis* be also applied to claims for temporary disablement benefit and maternity benefit for sickness arising out of pregnancy, confinement or miscarriage, etc.

Scrutiny of claim by claims clerk

P.7.23. As he takes up certificates of an insured person with a view to preparing the sickness benefit claim, the claims clerk will apply the following initial checks to them:

- (i) The certificate(s) issued is/are genuine. For this, he should refer to book number, size, the water mark, design, style of printing and other specifications. The style of writing of the certificate(s) and the medical officer’s signature are such as not to arouse suspicion.
- (ii) The certificates are regular, i. e., the certificates issued cover all the days of the spell in unbroken succession and the certificates are issued at permissible intervals. For details of checks to be applied please refer to Chapter II - Certification.

- (iii) The treating medical officer has not given any remarks in the certificates which may need decision by the Manager or by Regional Office.
- (iv) All the certificates have been submitted within time-limits prescribed in Regulation 64.
- (v) The period and nature of incapacity is not one on which an incapacity reference is necessary. Or, it is not one on which an incapacity reference is pending and Medical Referee's decision is awaited.
- (vi) The claim is not one for which information is awaited from RO, IMO or the employer. If this be the case, IP may be asked to call again on a specific day.

Preparation of claim

P.7.24 The claims clerk will then assist the insured person in filling up form 9 which is the newly devised claim form. This form contains all the possible alternatives which may be relevant in different situations irrespective of the type of incapacity. When the insured person is claiming sickness benefit/temporary disablement benefit, it will be ensured by the claims clerk that columns (iii) and (iv) of this form are correctly filled in by the insured person and that, on being questioned, the claimant confirms having not availed of a paid holiday/paid leave nor was he on strike during the period covered by the claim.

P.7.25 As for columns (i) and (ii) of the claim form, column (i) alone will be filled up in case of claims for every benefit based on 1st and intermediate/special intermediate certificate. In all other combinations of certificates, both columns (i) and (ii) will be filled in. A single claim would be sufficient even where claim for benefit is based on more than one certificate.

P.7.26 The claims clerk will then diarise the certificates if not already done, put 'CANCELLED' stamp diagonally across each, calculate the sickness benefit admissible after deducting two waiting days if required, make entries in the IP's ledger sheet in the appropriate columns, enter the progressive total, prepare the benefit payment docket and slip, append his dated initials in the space/columns provided and pass on the ledger sheet with the claim papers inserted in it to the checker for checking and onward transmission to the Manager.

Issue of Regret Slip

P.7.27. If claims clerk finds that an insured person cannot be paid sickness benefit for any reason whatsoever, he will immediately prepare a regret slip and pass it on to the checker for signature and issue. Such an insured person should not be made to wait alongwith others who are waiting to receive their sickness benefit.

Payment of claim

P.7.28. After checker has checked the claim, he will put his dated initials in column 17 whereafter the payment docket alongwith the ledger will be passed on to the –

- Manager for passing claim and dated initials in column 18 and then to the __
- Cashier for making payment and entries of payment in column 19 to 21 in the ledger. While making payment, all the claims will be rubber stamped as "PAID" by Cashier. The paid docket will be retained by the Cashier and the ledger will be returned to the counter clerk.

Payment on special intermediate certificate

P.7.29. A special intermediate certificate certifies incapacity in advance. But payment of benefit is not made in advance and it must be made weekly or periodically only after the expiry of the week or the

period covered by each claim. Further, payment for the last six days covered by this certificate is withheld until receipt of a subsequent certificate so as to avoid the possibility of over-payment in the event of an insured person becoming fit and resuming duty earlier than the last date covered by the special intermediate certificate. However, when no subsequent certificate follows the special intermediate certificate, payment for the last six days should be made only after verifying from the employer the exact period for which the insured person was absent from work during the period covered by the special intermediate certificate.

P.7.30. Under regulation 52, payment of sickness benefit must be made within 7 days of the date of the claim and not the date of receipt of the certificate. In the case of special intermediate certificate, the two dates will not be the same. Further, even if payment is made after a week, it does not attract the provisions of Regulation 52.

Alternative evidence of incapacity

P.7.31. When an insured person submits an alternative evidence of incapacity, the receptionist/counter clerk will guide him to the claims clerk. The claims clerk will ask the claimant to fill up a claim on form 9 (separate from the certificate), as the case may be. The claim will be diarised in the claims diary in the usual way and particulars in the register of alternative evidence in form ESIC-62 will also be completed.

P.7.32. The claims/counter clerk will examine the papers and enter the particulars in ESIC-127 - copy at Annexure I to Chapter II-Certification and put up to the Manager who would deal with them in accordance with detailed instructions given in the said Chapter.

Incapacity references

P.7.33. Incapacity references to the Medical Referee are to be made by the Branch Office in accordance with the procedure indicated in Chapter XI.

Measures to control the incidence of benefit

P.7.34. It is essential to ensure that the sickness benefit provided under the Scheme is drawn only by those who are in fact entitled for the same and under conditions really necessitating abstention from work on medical grounds and that unnecessary strain on the ESI Fund is not caused by claims which are not really genuine. Every effort should be made to keep statutory cash benefits strictly within the limits of law and to prevent their abuse.

P.7.35. To meet this objective, the first step the B.M should take is to look around and see if the employees of any factory/establishment are on strike. He will probably come to know of this strike in no time even from the movement of certificates or of the IPs. In such circumstances, he should immediately contact the management of the factory/establishment under strike and obtain the names of covered IPs who are on strike and he should stop payment of sickness benefit/temporary disablement benefit to those who may have submitted medical certificates for the period of strike. He should also instruct the receptionist to segregate the certificates of those IPs who are on strike and hand them over to the B.M who shall keep them in custody in a separate cover. The list of persons on strike should also be kept by claims clerk and the checker in addition to the B.M..

Certain exceptions in which payment of SB/TDB to such employees will, however, continue are provided in para L.7.19 of the 'Law' Part of this Chapter.

P.7.36. The other reason for a sudden spurt in medical certification could be the lockout of a factory or establishment. B.M has to be equally watchful because payment of SB/TDB cannot be denied to those employees who are affected by the lockout and who produce medical certificates. A close watch over the situation personally by B.M, assisted by his staff would help him contain and curb medical certification of employees under lockout.

P.7.37. Other measures recommended to B.M for keeping incidence of sickness benefit under control are given below:

P.7.38. Apart from the contingencies of strike or lockout, there appears to be a general trend to avail of cash benefits on the slightest pretext even in normal times. In order to achieve better results B.M should enlist the full co-operation of the local labour leaders. It is essential that the Local Committees meet frequently and are fully posted with such developments within their local area, so that they could exercise an educative and healthy influence on the insured persons and that they realise that the ESI Fund is actually meant for those who really need it. Apart from formal meetings, it is desirable to maintain close liaison with active labour leaders and if the circumstances at any time so warrant, the situation should be brought to their notice and their co-operation enlisted to get better results.

P.7.39. While due vigilance has to be exercised, discretion should be used and the B.M should act in such an unostentatious manner as not to provoke any untoward incidents. Should there, however, appear to be any possibility of a law-and-order situation arising, the Manager should contact the appropriate Local/State Government authorities without delay and request them to issue instructions to give necessary protection to the staff of the dispensaries and the Branch Office.

P.7.40. Apart from contingency measures outlined in the foregoing paras for controlling excessive incidence arising out of a strike or a lockout, the Manager has to keep the incidence of sickness and temporary disablement in respect of his Branch Office constantly under his personal surveillance and undertake measures as and when he notices a marked increase. For this he should take the following action :-

- (i) At the end of each month, the Branch Office should work out the average daily number of medical certificates received and payments made during the month. This can be done from the schedule of benefits paid and the claims diaries.
- (ii) The number of certificates received and the number of payments made every day will be compared with the daily averages for the preceding months.
- (iii) If any marked increase either in the number of certificates received or the number of payments made is noticed to have persisted for a couple of days, the Manager should personally try to ascertain the exact causes of the increase, e. g., whether it is due to harvesting season, festival, lockout, or closure of factory, etc.
- (iv) A detailed report should then immediately be sent by him to the Regional Office indicating the figures relating to the increase and the causes which in his opinion account for the increase.
- (v) The Branch Office should initiate more incapacity references to be disposed of in the ordinary course. In addition to the routine references, Branch Office may, under intimation to Medical Referee in suspected cases of malingering, direct the insured person in writing to report to the Medical Referee on any of the following 2 or 3 days at the dispensary or the examining centre of the Medical Referee under the panel system which the Medical Referee is scheduled to visit on that day. The Branch Office should simultaneously issue R. M. 3 to the IMO/IMP concerned on behalf of the Medical Referee with the request to complete the form and send it to the Medical Referee so as to reach him before the date fixed for examination.
- (vi) The Branch Office concerned should continue to watch the situation and send weekly reports indicating the trend of the incidence of medical certification and payments to the Regional Office for further analysis. This should be continued till the position returns to normal or till instructions to the contrary are received from the Regional Office.

P.7.41. As an additional step towards curbing lax certification, the Branch Manager should forward to the concerned IMO/IMP through a letter (Annexure-I) the particulars of all insured persons who have availed of 50 days' sickness benefit in two consecutive benefit periods so that the IMO/IMP may remain on guard while issuing further certificates to such insured persons.

P.7.42. For curbing excessive incidence of temporary disablement benefit please see Chapter IV – Temporary Disablement Benefit Procedure.

Enquiries regarding abstention from work

P.7.43. The procedure for making inquiries regarding abstention is as indicated in Chapter XI.

Bar on benefits to convicted insured persons

P.7.44. In paragraph L.7.24 of the “Law” Part of this Chapter, it has been laid down that *vide* the amended Section 84 of the Act read with Rule 62 of the Central Rules, if an IP is convicted for giving false statement, he will be barred from any cash benefit admissible under the Act for three months for the first conviction and six months for each subsequent conviction from the date of receipt of the Court judgement in the concerned office of the Corporation. The procedure under this new provision is given below :-

- (1) Whenever the judgement under Section 84 of the ESI Act is delivered by the Court, the Insurance Inspector or the Branch Manager who is attending the Court on a particular date, may file an application immediately for certified copy of the judgement and pursue the same for early receipt. On receipt of the certified copy of the order of the Court, the Branch Manager may issue a Regd. A. D. letter -ESIC-96-A (Annexure II) to the convicted insured person specifying the period for which he is barred from receipt of any cash benefit, with a copy to Regional Office alongwith certified copy of the order of the Court for information and record.
- (2) Where the work of attending the Court is entrusted to Insurance Inspector (Legal) at Regional Hqrs., the Insurance Inspector will obtain a certified copy of the order of the Court and submit the same to Regional Office immediately. On receipt of the copy of the order, the Regional Office may issue a Regd. A. D. letter (ESIC-96-A) to the insured person specifying the period for which he is barred from receipt of the cash benefit, with a copy to B.M concerned alongwith a copy of the Court order, with directions to take appropriate action.
- (3) The Branch Manager, after completing above mentioned formalities, will make necessary entry in the ledger sheet of the concerned insured person indicating the case number and period for which he is barred from receipt of cash benefit etc. No further payments will be made to the insured person if any certificate is received for the subsequent periods falling within the period for which such insured person is barred.

P.7.45. Similar entries will also be made in the PDB register if the convicted IP is in receipt of PDB which will be suspended for the period specified *vide* paras L.3.39 and L.3.40 of General Claims Law Chapter III

Contributory record from employer

P.7.46. In cases where the rate of benefit cannot be calculated due to non-receipt of return of contributions from the employer, contributory record in form ESIC-71 should be obtained from the employer and rate be calculated on the basis of information supplied by the employer. Procedure to be followed in such cases is described below :-

- (i) The Branch Office should call for the contributory record from the employer in form ESIC-71 only where the RC has not been received.

- (ii) ESIC-71 should not be signed by officials other than the Manager/Head Clerk/Upper Division Clerk.
- (iii) ESIC-71 on its return from employer should be accepted only if it is signed by the employer himself or by one whom employer has intimated as authorised signatory and by no one else. It should also have rubber stamp of the employer.
- (iv) On receipt of form ESIC-71, the Branch Office should decide the eligibility to cash benefit, calculate the rate of benefit and make payment accordingly.
- (v) The Branch Office will maintain a record of cases where contributory record on form ESIC-71 has been called and payment made on the basis thereof, in a register in proforma 'A' at Annexure III. The cases recorded will also include cases of TDB rates prepared on the basis of ESIC-32, ESIC-71 referred to the para P.4.57.
- (vi) The Branch Office should watch the receipt of return of contributions from the employer.
- (vii) On receipt of the return of contributions ex-post-facto check of the information furnished by the employer on ESIC-71 and confirmation of the rate calculated on the basis of ESIC-71 with the particulars in the return of contributions will be carried out at the Branch Office.

P.7.47. In all cases where RC is not received even after the expiry of the benefit period, return in proforma 'B' at Annexure IV should be forwarded by Branch Office to Regional Office after verification of the wage-cum-attendance record, for taking legal action for recovery of contributions. If there is no case for report, a 'nil' return may be sent. Please also see para P.3.21 which lays down a combined statement to be submitted to Hqrs. under the said para as well as this one.

P.7.48. Where a supplementary return of contributions in respect of an insured person is received from the same employer making the insured person eligible to benefit after he has been found to be ineligible initially on the basis of first return of contributions, in all such cases, B.M must personally verify the particulars with the wage record of the employer before determining the eligibility and making payment of cash benefit to the insured person, in order to ensure that there is no manipulation.

P.7.49. On receipt of the statement at Regional Office, it should be checked whether the employer is a total defaulter or a partial defaulter. If the employer is a partial defaulter, revenue recovery action would be taken for recovery of contributions shown due as per particulars furnished by the Branch Office.

P.7.50. Every Regional Director has to furnish a certificate/report to the Headquarters Office within two months of the close of a benefit period certifying therein that the returns in proforma 'B' have been received from all the Branch Offices in his region and that further action as per prescribed procedure is being taken at the Regional Office.

II-ENHANCED SICKNESS BENEFIT PROCEDURE

Introduction

P.7.51. Enhanced sickness benefit was introduced with effect from 1st August 1976 as an incentive to IPs/IWs for undergoing vasectomy/tubectomy operation towards family planning.

Duration

P.7.52.1. Enhanced sickness benefit is payable for a maximum period of – (i) 7 days for vasectomy operation and (ii) 14 days for tubectomy operation right from the date of operation or from the date of admission in the hospital, as the case may be.

P.7.52.2. The IP/IW, to be entitled to enhanced sickness benefit, must abstain from work for the period claimed by him/her. Where there is no abstention from work on medical grounds on the date of operation, the period of 7 days/14 days will be reckoned from the date following.

P.7.52.3. Enhanced sickness benefit may continue to be paid upto 21 days in tubectomy cases where longer abstention from work is certified by the Medical Superintendent of the hospital in which the operation was conducted, to be necessary due to post-operative complications or for other related medical grounds.

P.7.52.4. Enhanced sickness benefit for vasectomy is not ordinarily payable beyond 7 days. However, in case of post-operative complications, benefit for over 7 days may be sanctioned by the Regional Director in consultation with SMC/full time Medical Referee.

P.7.52.5. Similarly, enhanced sickness benefit beyond 21 days in case of tubectomy may also be sanctioned by the Regional Director in consultation with SMC/full time Medical Referee.

P.7.52.6. Where the date of operation and the date of admission into hospital are different, the spell of enhanced sickness benefit will commence from the date of operation or the date of admission into the hospital, whichever is earlier.

Enhanced sickness benefit is exclusive of SB

P.7.53.1. The days for which enhanced sickness benefit is paid for vasectomy/tubectomy will be exclusive of the duration for which ordinary sickness benefit is payable.

P.7.53.2. Waiting period of 2 days shall also not apply in these cases. Also no waiting period will apply where a spell of enhanced sickness benefit is followed by a spell of ordinary sickness benefit either in continuation or within 15 days of the spell of enhanced sickness benefit.

Eligibility condition

P.7.54. For receiving enhanced sickness benefit, IP/IW must satisfy the eligibility condition as for sickness benefit.

Rate of benefit

P.7.55. Daily rate of enhanced sickness benefit shall be twice the standard benefit rate applicable for the benefit period in which the spell certified for vasectomy/tubectomy falls. If the certified spell falls partially in one benefit period and partially in the next following, eligibility and rate of enhanced sickness benefit will be determined afresh as in the case of ordinary sickness benefit.

Certification

P.7.56.1. Regulation Certificates showing diagnosis as “vasectomy”, “tubectomy”, “vasectomy complications”, or “tubectomy complications” etc. will be acceptable at the Branch Office for payment of enhanced sickness benefit.

P.7.56.2. Where the IP/IW has undergone sterilisation operation in a family planning camp organised by the State Government/local authorities/employer etc. and the IP/IW has not obtained regulation certificates from the IMO/IMP, the certificate submitted by IP/IW in this behalf may be accepted as alternative evidence.

P.7.56.3. Branch Manager is authorised to accept the certificate of sterilisation covering a back period of 7 days after satisfying himself about the genuineness of the certificate. Where the back period exceeds 7 days, the matter will be referred to Regional Office with full justification for its acceptance.

Certificates and claims for enhanced sickness benefit

P.7.57. The same forms will be used and the same procedure will be followed as in the case of certified incapacity for other benefits under the ESI Scheme. Regulation 64 will also equally apply in respect of medical certificates for enhanced sickness benefit.

Head of account

P.7.58. The expenditure on enhanced sickness benefit will be booked in the schedule sheet in separate column with suitable remarks. The expenditure on enhanced sickness benefit will be booked in the accounts of the Corporation as “B-cash benefits – (ii) enhanced sickness benefit”.

Enhanced sickness benefit can not be continued with SB/ESB

P.7.59. Neither enhanced sickness benefit and SB nor enhanced sickness benefit and ESB can be claimed for the same period. An insured person who undergoes sterilisation operation while in receipt of ESB can claim enhanced sickness benefit for such operation if otherwise eligible instead of ESB, whereafter ESB can be resumed.

Other incentives available

P.7.60. Enhanced sickness benefit can be paid in addition to any other incentives, if any, given to the insured person by any other organisation.

No deduction for paid leave/paid holiday/strike

P.7.61. Enhanced sickness benefit is payable even when during the period of certified incapacity for enhanced sickness benefit, the IP/IW may avail paid leave/paid holiday or be on strike.

BRANCH OFFICE _____
EMPLOYEES' STATE INSURANCE CORPORATION

To

The Insurance Medical Officer Incharge,
.....Dispensary,
.....,
Insurance Medical Practitioner,
.....

Sir,

I have to inform you that Shri....., Insurance No..... has
availed of 50 days' sickness benefit during the two consecutive benefit periods as on date. You are
requested to please keep this in view while issuing further certificates to him.

Yours faithfully,

***REGIONAL/BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION**

No. _____

Dated: _____

To

Shri/Smt. _____
Ins. No . _____

Subject: BAR ON GRANT OF CASH BENEFIT UNDER RULE 62
OF ESI (CENTRAL) RULES, 1950

Sir/Madam,

I have to state that you have been convicted on _____ by _____ Court _____ under Section 84 of the ESI Act, 1948 (as amended) for false statement (Case No. _____) and awarded/imposed with punishment/fine for first/second/subsequent offence. You will not be entitled to receive any cash benefit under the Act for the period of three/Six months from _____ to _____ in view of Rule 62 of ESI (Central) Rules, 1950.

Yours faithfully,

***MANAGER/ASST./DY. REGIONAL DIRECTOR**

Copy to:-

*Regional/Branch Office _____, for information and necessary action. A copy of the order of the Court is enclosed for perusal and record.

***MANAGER/ASST./DY. REGIONAL DIRECTOR**

*Strike out whichever is not applicable

PROFORMA 'A'

**Register Showing the Particulars of the Contributory Record
Called for from the Employer and Payments made at the Branch Office**

S. No.	Insurance Number	Name of the insured person	Employer's name and code number	Date of issue of ESIC-71 and contribution period for which issued
1	2	3	4	5

Date on which ESIC-71 received	No. of days for which wages paid	Total amount of wages paid	Date of calculation of the rate	Date of payment	Whether RC received & ex-post-facto check done
6	7	8	9	10	11

RESULT OF RECHECK

Rate as confirmed by reference to original RC in 100% cases	In case of non-receipt of RC whether verification of attendance-cum-wage record conducted, if so, result thereof
11(a)	11(b)

Reference No. of the register in the proforma 'B' if case referred to Regional Office	Reference to excess payment register, if any	Remarks
11(c)	12	13

PROFORMA 'B'

**Statement for recovery of contribution in respect of
ESIC-71 cases for Branch Office.....for
Benefit Period ended.....**

S. No.	Insurance Number	Employer's		Reference to ESIC-71 Register	Wages-cum-attendance verification	
		Code No.	Name		Date	Result
1	2	3	4	5	6	7
Total amount recoverable			Eligibility confirmed on the basis of records at Regional Office		Remarks	
Brief reasons		Amount				
8		9		10	11	

CHAPTER VIII

EXTENDED SICKNESS BENEFIT LAW

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CHAPTER VIII

EXTENDED SICKNESS BENEFIT LAW

Corporation's Powers

L.8.1 Section 99¹ of the Act says, "At any time when its funds so permit, the Corporation may enhance the scale of any benefit admissible under this Act and the period for which such benefit may be given, and provide or contribute towards the cost of medical care for the families of insured persons."

Evolution of ESB to this day

L.8.2 In exercise of the aforesaid power, the ESI Corporation at its meeting held on 17.12.55, granted extended sickness benefit to insured persons suffering from Tuberculosis subject to minimum qualifying service, for a period of 18 weeks (126 days) at a rate (i) which should not exceed the daily rate of sickness benefit (applicable for persons whose sickness benefit rate was then below As. -/12/- per day), (ii) which should not be less than annas twelve (for persons whose daily rates were below Rs. 1/8/- per day) and (iii) which should be half the daily sickness benefit rate rounded to the next higher anna for higher sickness benefit rates. By a resolution passed by the Corporation at its meeting held on 1.4.59, this benefit was extended to persons suffering from leprosy, mental and malignant diseases subject to the same qualifying condition and at rates as for tuberculosis. Later, at its meeting held on 23.8.60, the Corporation extended the period of this benefit to 309 days during an extended benefit period of 3 years. Subsequently, more diseases were added from time to time to the list of diseases for which extended sickness benefit was payable and there was no other change. At its meeting held on 22.3.66, the ESI Corporation resolved, "Where an insured person has completed 4 contribution periods immediately preceding the commencement of the relevant spell of sickness, he shall be deemed to have completed two years' continuous service if contributions paid by him in three out of the said four completed contribution periods entitle him to sickness benefit in the corresponding benefit period."

L.8.3. By a resolution passed by the Corporation at its meeting held on 22.3.69, two lists of diseases were introduced: diseases in group 'A' entitled sufferer to extended sickness benefit for 309 days and those in Group 'B' entitled him to extended sickness benefit for 124 days. The lists approved in this meeting were later replaced by two new lists by a resolution of the Corporation dated 14.2.70 and became effective from 1.4.70. Finally, at its meeting held on 28.2.76 the Corporation adopted a new resolution effective 1.4.76 wherein a list of 21 diseases was approved for payment of extended sickness benefit for a period of 124 days which could be extended to 309 days in the extended sickness period of 3 years. One more disease monoplegia was subsequently added to it with effect from the same date by means of Corporation's Resolution passed at its meeting held on 25-2-1978. Later, the Corporation, by a Resolution passed at its meeting held on 15-12-1992, approved the addition of 7 more diseases to the list and it also amended the nomenclature of the disease "Cirrhosis of the Liver with ascites" appearing at Sl. No. 15 of the original Resolution dated 28-2-1976, to "Cirrhosis of the liver". The foregoing two amendments were effected from 1-1-1994. A copy of the Corporation's Resolution dated 28-2-1976, as amended from time to time, is at Annexure 'A'.

¹ Act No. 29 of 1989 has replaced this Section which now reads as under:-

"99. Medical care for families of insured persons:- At any time when its funds so permit, the Corporation may provide or contribute towards the cost of medical care for the families of insured persons"

The foregoing section as now amended has not been enforced to the date of publication of this Manual. Hence old provision as given in the above para continues in force.

Corporation’s New Resolution

L.8.4. The ESI Corporation at its meeting held on 5.12.1999 adopted a new Resolution on long-term diseases in place of the Resolution dated 28-2-1976. A copy of the new Resolution is at Annexure ‘B’. Salient differences of the new Resolution from the old Resolution are as under:-

- (1) A new list of diseases has replaced the earlier list (See Annexure ‘B’)
- (2) Contributory condition for ESB has been reduced from 183 days to 156 days. Other conditions remain unchanged.
- (3) The following changes have been made from the old list of 29 diseases:-

A. New diseases added

Sl. no. of new list	Name of disease
5	Interstitial lung disease
6	AIDS
8	Diabetes mellitus with proliferative retinopathy/diabetic foot/nephropathy
16	Myaesthesia gravis/Neuromuscular dystrophies
23	Cardiomyopathies
24	Heart disease with surgical intervention alongwith complications
26	Chronic active hepatitis (“C. A. H.”)
34	Reynaud’s disease/Burger’s disease

B. Nomenclature changed:

Sl. No. in old list	Name in old list	Sl. No. in new list	Name in new list
7	Chronic congestive heart failure	21	Congestive heart failure left / right
11	Myocardial infarction	20	Cononay artery disease: a) Unstable Angina b) Myocardial infarction with ejection less than 45%
15	Cirrhosis of Liver	26	Cirrhosis of liver with ascitis
18	Empyema	3	Chronic Empyema

21	Chronic (simple) primary glaucoma	19	Glaucoma
25	Hemiparesis of more than eight weeks' duration	12	Hemiparesis
27	More than 50% burns	32	More than 20% burns with infection/ complications
29	Chronic cor pulmonale with congestive heart failure	25	Chronic obstructive lung disease (COPD) with congestive heart failure (cor pulmonale)

C. Diseases deleted

1. Lung abscess (S.No. 10 of old list)
2. Aplastic anaemia (S.No. 14 of old list)

However, insured persons suffering from these diseases who were eligible for ESB in respect of a spell which commenced before 1-1-2000 would continue to be eligible for ESB for 124/309/730 days as the case may be, during the ESB period of 3 years in accordance with the old Resolution dated 28-2-1976 till (i) the spell is terminated, or (ii) ESB period comes to an end or (iii) an IP on extension of ESB beyond 309 days reaches the age of 60 years where extension beyond 309 days is involved, whichever happens the earliest.

D. Grouped/bracketed diseases

Some of the diseases shown in Annexure 'B' are grouped/bracketed with other more or less similar diseases, ESB is admissible for each such single disease or in combination with other bracketed disease as detailed below:-

S.No. in the list of diseases in Annexure 'B'	Nature of disease grouped/bracketed with the other
8	Diabetes mellitus with proliferative retinopathy and/or Diabetes mellitus with diabetic foot, and/or diabetes mellitus with nephropathy (ESB for diabetes Mellitus alone is not admissible)
16	Myaesthesia gravis, and/or neuromuscular dystrophies
20	Coronary artery disease – (a) Unstable angina, and/or (b) Myocardial infarction with ejection less than 45%
26	Cirrhosis of liver with ascitis, and/or Chronic active hepatitis (CAH)
27	Dislocation of vertebra and/or Prolapse of intervertebral disc
34	Reynaud's disease and/or Burgers's disease

(4) Explanation (c) added below para 2 of the Resolution dated 05-12-1999, reads as under:-

“A person in insurable employment may go out of coverage due to enhancement of wages and may be brought under coverage subsequently. The period of interruption should also be taken as insurable employment for the purpose of the term continuous service”.

(5) As per para 8, the limit of extension to two years (730 days), after ESB is extended beyond 309 days, will exclude only those days on which sickness benefit for any other disease is paid to the insured person but include all those days for which SB is paid for the same disease on which extension is sanctioned beyond 309 days.

(6) As per para 14, the period for which ESB may be paid to an insured person suffering from disability arising from administration of drugs/injections has been enhanced upto the limit of 2 years (730 days). This extension is also limited to the date on which IP reaches 60 years of age.

(7) As per para 16, the new Resolution has been enforced from 1-1-2000.

(8) The period of two years will be reckoned as 730 days.

Some diseases explained

L.8.5. Explanation about some of the diseases included in the above list will be found helpful in deciding eligibility of the disease for ESB.

Tuberculosis (Group I)

L.8.6. Tuberculosis includes all forms including lungs, bones, organs and other sites and it also includes 'pleurisy with effusion'. 'Pleurisy' mentioned singly in a medical certificate does not entitle an insured person to ESB, but "pleurisy with effusion", when mentioned in a certificate is to be deemed as tuberculosis unless the IMO specifies it as 'non-tubercular'.

Malignant diseases (Group II)

L.8.7. These are cancerous growths for which ESB is payable. It is to be noted that some of the diseases can be both malignant for which ESB is payable and benign (harmless growths) for which ESB is not payable. The diagnosis mentioned in a certificate has to be treated as for a malignant disease unless otherwise remarked .

Mental diseases – Psychoses (Group X)

L.8.8. Four sub-groups namely (a) schizophrenia (b) endogenous depression (c) manic depressive psychosis (MDP) and (d) dementia have been listed under this heading which really means mental diseases. Out of these, psychoses and psychoneuroses are medical names given to a state of tension or nervousness, gifts of present-day fast living which are conditions more or less present in all those who live an active life. Only if these conditions become morbid, i. e., when they result in sickness needing active treatment that SB/ESB becomes payable. So, whenever a certificate with 'Psychoses' or 'Psychoneuroses' is received, it will be advisable to get SMC's / Medical Referee's confirmation towards payment of ESB.

Cataract

L.8.9.1. Immature cataract with vision 6/60 or less in the affected eye is admissible for ESB payment even for single eye, the other being normal. ESB is also payable for further deterioration of the

condition, viz., mature cataract, or conditions like operated cataract, post-operation period of cataract with or without complications until the insured person is declared fit.

L.8.9.2. For payment of ESB for cataract, i. e., “immature cataract with vision 6/60 or less in the affected eye” etc., contributory condition has to be satisfied separately for each eye, and shall have separate ESB periods, unless the condition is present in both eyes which have to be operated simultaneously or one eye is operated immediately after the other in the same spell of sickness in which case contributory condition will be satisfied as for a single eye and there will be only one ESB Period.

Myocardial infarction

L.8.10. This means formation of dead tissue in the portion of heart affected by stoppage of blood-supply to it because of the blocking of a branch of the coronary artery, i. e., a thrombosis. Coronary thrombosis is also to be treated as myocardial infarction for payment of ESB even though the diagnosis in the certificate may say simply ‘Coronary thrombosis’. Further, with effect from 1.1.2000, ESB is payable only for “myocardial infarction with ejection less than 45%”.

L.8.11. “Bronchiectasis” is a disease for which ESB is payable, but it is often confused with “bronchitis” for which ESB is not payable.

Disorders of nervous system (Group IV)

L.8.12. Spinal cord compression has been mentioned at Sl. No. 14 of the Resolution at Annexure ‘B’. This disease may be responsible for quadriplegia which means paralysis of both upper and lower parts of the body. Thus, ESB is admissible for quadriplegia also.

Rare Disease

L.8.13. In addition to the above list, for a case of any rare disease or special circumstances which have not been included in it, the Director General/Medical Commissioner has been authorised by the Corporation to sanction payment of ESB for a maximum period of 730 days depending on the merits of each case on the recommendation of the State Medical Commissioner/Medical Referee/Administrative Medical Officer or his nominee.

Period for which ESB payable

L.8.14.1. The Corporation, at its meeting held on 24-2-1994, by a Resolution, amended paragraph 4 of its earlier Resolution dated 28-2-1976, to read as under:

“4. ESB shall be payable for a maximum period of 124 days initially which may be extended upto 309 days in chronic suitable cases by the SSMC/SMC/MR/AMO (Chief Executive of the ESI Scheme in the State) or his nominee on the report of the Specialist, where abstention from work is recommended for a total period of more than 124 days for any listed disease.

The Director General be empowered to enhance the duration of extended sickness benefit beyond the present limit of 400 days (91 days of sickness benefit plus 309 days of extended sickness benefit) to a maximum period of two years in deserving cases duly certified by a Medical Board. Facility for extension of ESB beyond the period of 400 days would be available upto the date on which the insured person attains the age of 60 years.”

- (1) The above amended para came into force from 1-4-1994 and was applicable in respect of cases arising on or after that date.
- (2) Cases where the insured persons were in receipt of extended sickness benefit as on 1-4-1994 were to be governed by the above amended para.

- (3) Cases where the period of three years for ESB was current as on 1-4-1994 would also be governed by the provisions of the above amended para.

L.8.14.2. Vide Para 5 of Corporations' Resolution dtd. 5.12.1999 at Annexure 'B', the Regional Director has been authorised in deserving cases on the recommendation of the SMC / MR and duly certified by a Medical Board, to enhance the duration of ESB beyond 400 days (i. e. 91 days of sickness benefit and 309 days of extended sickness benefit) to a maximum of 2 years (i. e., 730 days). The aforesaid extension of ESB beyond 400 days would be admissible upto the date on which the insured person attains the age of 60 years. Thus, the facility of extension of ESB beyond 400 days has continued to be available from 1-4-1994 onwards, but such cases no longer need Director General's approval/sanction.

L.8.14.3. The age limit of 60 years is applicable only for those cases where extension of ESB is allowed beyond 309 days. In other words, ESB upto 309 days will continue to be payable irrespective of the fact that an IP may have crossed 60 years of age while in receipt of ESB within the limit of 309 days.

Continuous employment condition prior to 1.1.2000

L.8.15.1 Para 2 of the Corporation's Resolution dated 28-2-1976 as amended by its Resolution dated 20-02-1989, now states *inter alia* that to be entitled to ESB an insured person should have been at the beginning of the spell of the sickness in which the disease is diagnosed, in continuous employment for a period of two years or more in a factory or establishment to which benefit provisions of the Act apply. The Explanation below this Resolution says that employment shall be held to be continuous-

- (a) for periods preceding 'A-Day', if the person was in continuous service as defined in Section 25-B of the Industrial Disputes Act, 1947 as amended by Act 36 of 1964 (extract of the said section 25-B at Annexure 'C') and
- (b) for periods after 'A-Day', if the insured person has completed 4 contribution periods immediately preceding the relevant date and has paid contribution for sickness benefit for a period of 183 days in the 4 aforesaid contribution periods and he is eligible to claim sickness benefit atleast in one of the aforesaid contribution periods. (effective from 1-4-89).

Qualifying condition effective 1-1-2000

L.8.15.2. The Corporation's Resolution dated 05-12-1999 (Annexure'B') also contains almost similar clauses (a) and (b) under Explanation below Para 2 thereof. However, the latest Resolution contains an additional explanation (c) thereunder, namely-

“(c) A person in insurable employment may go out of coverage due to enhancement of wages and may be brought under coverage subsequently. The period of interruption should also be taken as insurable employment for the purpose of the term 'continuous service'.”

A careful reading of the first sentence in this clause will reveal that only that period of interruption should be counted which was actually spent in insurable employment. 'Insurable employment', as per Section 2(13A) of the Act means an employment in a factory or establishment to which the ESI Act applies.

Service condition before 'A-Day'

L.8.16. Vide clause (b) of Regulation 2 of ESI (General) Regulations, 1950 "appointed day" means with reference to any area, factory or establishment, the day from which Chapter IV and Chapter V of the Act apply to such area, factory or establishment, as the case may be. Keeping this definition of appointed day in view, we come across the following cases of those insured persons whose eligibility to ESB will

need to be determined with reference to continuous employment as stated in item (a) of para L.8.15.1 i. e., insured persons who have not completed four contribution periods before the relevant date:

Particulars of the case	Eligibility to ESB
<p>1) The ESI Scheme is implemented for the first time in an area under Sec. 1(3) of the ESI Act and is later extended to establishments under Sec. 1(5) of the Act and an insured person's spell of sickness commences in the first benefit period. (This also includes cases where the said first spell commenced before the start of the first benefit period but continued into first benefit period.)</p>	<p>He will be eligible to ESB if :-</p> <p>(a) before the date of start of this spell of sickness he had been in continuous service as defined in Sec. 25-B of the Industrial Disputes Act, 1947, for a period of 2 years or more either in a factory in terms of Sec. 2(12) or an establishment in terms of Sec. 1(5) of the ESI Act, and</p> <p>(b) he has qualified to claim sickness benefit in the first benefit period.</p>
<p>2) The spell of sickness of an insured person covered as an employee under the ESI Act since the 'A-Day' for the area, starts before completion of four contribution periods by him.</p>	<p>He will be eligible to ESB if :-</p> <p>(a) he fulfils the condition (a) of item (1) above, and</p> <p>(b) he fulfils the contributory condition for sickness benefit in at least one of the contribution periods expired after the appointed day.</p>
<p>3) A person joins insurable employment in a covered factory/establishment after the appointed day for the area and suffers from one of the long-term diseases and the date of start of spell of sickness falls before completion of four contribution periods by him.</p>	<p>He will not normally be eligible to ESB during the spell unless he can produce evidence of having been in insurable employment in some other covered factory/establishment and having fulfilled the required contributory condition or unless the condition is relaxed by the Regional Director under powers delegated to his. [vide para 14/15 of old/new Resolution read with para 2(b) thereof]</p>
<p>4) A factory/establishment is covered under the Act after the appointed day for the area and insured person is in continuous service for 2 years as defined in Sec. 25-B of the I. D. Act, 1947 in the said establishment before the date of commencement of the spell of sickness for which ESB is admissible but has not completed four contribution periods from the date of coverage of the factory/establishment.</p>	<p>"Appointed Day" for this factory/ establishment is the date of its coverage under the ESI Act. Hence, two years' service condition may be applied to an employee of such a factory/establishment also even if it was covered from a date subsequent to the Appointed Day for this area. Eligibility to ESB in his case also will be determined in the same way as cases covered under item (1) and (2) above.</p>

Contributory condition after A-Day

L.8.17 Item (b) of Explanation under para 2 of the Corporation's Resolution, old as well as new, says that employment (of 2 years) shall be held to be continuous for periods after A-Day if the insured person has completed four contribution periods immediately preceding the relevant date and has paid contribution for a total period of 183 days (156 days w.e.f. 1-1-2000) in the aforesaid four contribution periods and he is eligible to claim sickness benefit atleast in one of the four contribution periods. Thus, there are two contributory conditions to be satisfied viz., (i) he should have paid 183 days' (156 days w.e.f. 1-1-2000) contribution in the four contribution periods immediately preceding the date of commencement of the spell of sickness in which he is diagnosed as suffering from one of the long-term diseases and (ii) he should have qualified for sickness benefit in atleast one of these four contribution periods.

L.8.17.2. Three dates will be relevant in this connection:

- 1-4-1989 Contributory condition of 183 days, apart from eligibility to sickness benefit in one out of relevant 4 contribution periods becomes effective.
- 19-9-1998 Contributory condition for eligibility to sickness benefit was reduced to 78 days in a contribution period.
- 1-1-2000 Contributory condition of 183 days in the relevant 4 contribution periods was reduced to 156 days.

Other conditions remaining unchanged, the eligibility to ESB has to be determined keeping in view the position prevailing on the aforesaid three dates. The following illustrations will be helpful.

Date of commencement of spell	Contribution periods involved	No. of days for which contributions paid	Eligibility to ESB
1-4-1989 onwards	April '87 to March '89	40+103+77+15 = 235 days	Eligible
19-9-1998 onwards	April '96 to March '98	60+45+40+80 = 225 days	Eligible
1-1-2000 onwards	Oct. '97 to Sept. '99	1) 40+26+20+90 = 176 days 2) 39+50+50+77 = 216 days	Eligible Not eligible

L.8.18. Hqrs. have laid down that the following requirements are to be fulfilled by the insured person for becoming eligible to ESB:

- a) The beneficiary should be an insured person on the date of commencement of extended sickness benefit spell.
- b) At the beginning of the spell, he should be in continuous employment for a period of 2 years or more in a covered factory or establishment. The term "continuous employment" means that the insured person should have completed 4 contribution periods immediately preceding the spell of sickness.
- c) The Contribution should have been paid/payable for 183 days (156 days w.e.f. 1-1-2000) in the above said 4 contribution periods in respect of the insured person.

- d) The insured person should have been eligible to claim sickness benefit atleast in one of these 4 contribution periods.

Hqrs. have also re-iterated that the insured person who does not fulfil the aforesaid 4 conditions will not be eligible to claim extended sickness benefit. [Please see in this connection, para L.8.27 and P.8.10]

Eligibility condition for drugs reaction

L.8.19. Para 14 of the Corporation’s Resolution dated 5-12-1999 (see Annexure ‘B’), says that when an insured person suffers from disability arising from administration of drugs/injections, Director General may subject to such conditions as he may like to impose on the merits of the case, sanction ESB for a maximum period upto two years (730 days) or until the disability lasts whichever is earlier, in addition to the sickness benefit subject to the incapacity being certified, at a rate at which ESB is payable to the insured person. Test of two years’ continuous service as applicable for the determination of entitlement of ESB referred to in para 2 of the said Resolution will not, however, apply in such cases. However, it is essential that insured person should have otherwise become eligible to sickness benefit for the spell of sickness/disability resulting from reaction to drugs/injections. Further, the extension beyond 309 days upto 2 years (730 days) will be limited to the date on which the insured person reaches the age of 60 years. Vide Head Office circular No. N-11/12/1/2008-Bft-II dt. 30.10.2008, the Director General has delegated this function to the SSMC / SMC. Such cases will henceforth be referred to SSMC / SMC for sanction of ESB.

Benefit when Payable

L.8.20. Extended sickness benefit is payable only after the insured person has exhausted sickness benefit due to him or is ineligible to it. In other words, when an insured person is eligible both for sickness benefit and extended sickness benefit for the same spell of sickness, he must first exhaust his sickness benefit whereafter ESB will be payable if the said spell of sickness is continuing. If a new benefit period commences during the spell of sickness for which ESB has been paid to an insured person, sickness benefit if admissible will first be paid to him, until he exhausts it and payment of ESB will be resumed thereafter if the spell is continuing.

Daily rate of ESB

L.8.21.1. As per para 8 of Corporation’s Resolution dated 28-2-1976 which remained effective from 1-4-1976 to 31-3-1994, the daily rate of ESB during the ESB period was 25% more than the standard benefit rate rounded to the next higher multiple of 5 paise applicable when the sickness benefit was last payable under the Act. By its Resolution dated 24-2-94, the Corporation has enhanced the ESB rate to 40% more than the standard benefit rate rounded to the next higher multiple of 5 paise applicable when the sickness benefit was last payable under the Act. The revised rate came into effect from 1-4-1994 and remains unchanged in the new Resolution dated 5.12.1999 (Annexure ‘B’).

L.8.21.2. The rate of ESB payable will be determined as follows in various types of cases: -

- (a) The insured person is qualified for sickness benefit in the new benefit period and receives the same for some days. ESB rate as above will be based on the standard benefit rate applicable for sickness benefit paid during the current benefit period
- (b) The insured person is not qualified to receive sickness benefit in the new benefit period ESB rate as above will remain unchanged and payment of ESB will continue

- | | | |
|-----|---|--|
| (c) | The insured person is qualified to claim sickness benefit but has availed of all 91 days in the previous period | ESB rate will be based on the new standard benefit rate in the current benefit period |
| (d) | The spell of sickness for which ESB is payable, commenced before the start of the benefit period corresponding to the relevant contribution period (i. e., 4 th contribution period which is the only one in which he has qualified for SB as per condition laid down in para 2(b) of Explanation as amended from time to time and IP was not eligible to SB in any of the earlier contribution periods. | ESB rate will be decided in the same manner as is done for TDB cases occurring before the commencement of the first benefit period. For this the employer will be asked to submit ESIC-32 which will be subjected to verification by the Branch Manager. |

ESB period

L.8.22. Once an insured person is qualified for ESB for a certain disease, he will be eligible to payment of this benefit for periods and subject to conditions laid down in other paras during an ESB period of 3 years reckoned from the date of start of the spell of sickness in case of tuberculosis and from the date of diagnosis in case of any other disease for which ESB is payable.

L.8.23. Since sickness benefit has to be first exhausted by the insured person, it follows that while in the case of tuberculosis payment of ESB will commence from the date following the exhaustion of sickness benefit, in case of other diseases it will commence either from the date following exhaustion of sickness benefit or from the date of diagnosis whichever happens later.

Waiting days

L.8.24. There may be instances where at the beginning of a spell of a long-term disease an insured person is not qualified for sickness benefit or even if qualified, he is otherwise ineligible having availed of sickness benefit for all the 91 days in the previous benefit period, but the nature of his ailment is such that he qualifies for ESB. In such a case, payment of ESB will commence from the first day itself without deduction of any waiting days as in the case of ordinary sickness benefit under Rule 55 of the ESI (Central) Rules, 1950. In other words, he will receive ESB from the date of start of sickness if suffering from tuberculosis or from the date of diagnosis if suffering from any other disease for which ESB is payable.

Premature termination of ESB period

L.8.25. Para 12 of Corporation's Resolution dated 5.12.1999 says as under:

12. If an Insured Person during the currency of an extended sickness benefit period for a particular disease, contracts any other disease for which he qualifies for ESB, the ESB for the first disease may be terminated on the date previous to the date of commencement of the spell or the date of diagnosis of the second disease as the case may be. The insured person should qualify for new disease based on the contributions paid in the relevant four contribution periods for the second disease.

In cases of the type mentioned in the above para, a new ESB period begins and it would then run for full 3 years during the course of which the insured person will not be paid any ESB for a relapse of the earlier disease though he would become eligible for payment of ESB for the subsequent disease for the full duration in the same way as in the case of the former disease.

Qualifying afresh

L.8.26. Para 11 of Corporation's Resolution dated 5-12-1999 says that after expiry of an ESB period, insured person may qualify afresh for ESB if he can satisfy the contributory condition again provided that this condition (of 2 years' continuous employment) is satisfied on a date following the date of termination of the ESB period in cases where the incapacity due to any of the diseases shown in para 1 thereof was continuing on the date of such termination. In other words, a person who exhausts ESB for a certain disease before termination of the ESB period but whose incapacity continues beyond the date of termination of the said period, can become eligible for payment of ESB for the same disease if he can qualify for it afresh by satisfying the requisite contributory condition. This includes cases where the IP was paid ESB upto the limit of 730 days.

Relaxation

L.8.27. Para 15 of the Resolution dated 5.12.1999 states that in case enforcement of any particular provision of Corporation's resolution is likely to cause substantial hardship to an insured person, the Director General / Insurance Commissioner may on humanitarian grounds relax the same.

Medical care for ESB Cases

L.8.28. Regulation 103-A specifies the periods for which an insured person is entitled to medical care in different circumstances. As regards entitlement of insured persons suffering from any of the long term diseases for which ESB is payable, proviso to sub-regulation (2) thereunder lays down that where a person suffering from any long-term disease for which ESB is payable, qualifies for extended sickness benefit either (i) by satisfying the 2 years' service condition or (ii) by relaxation of the same by the competent authority, he will be entitled to medical care till the end of the relevant extended benefit period. In other words such an insured person, during an ESB period of 3 years (see para L.8.22) will be entitled to medical care also until the end of the 3 years' ESB Period, irrespective of whether he suffers from the specific disease for which ESB was granted and is payable, or from some other disease for which ESB is not payable. Further, by virtue of sub-regulation (2) of Reg. 95-A the family of such an insured person will also be entitled to medical care until the end of ESB period. During this extended period, IP as well as his family will be entitled to all medical care including super-speciality medical treatment.

Protection from discharge

L.8.29. Under Reg. 98 (iii) an insured person who has been under medical treatment for any of the diseases for which ESB is payable can be discharged from service by his employer on due notice provided his conditions of service so allow, if the former has been under treatment for a continuous period of 18 months or more. Section 73 of the Act protects such persons from discharge or dismissal but the aforesaid Regulation limits the period to 18 months.

Extract of Resolutions passed by the ESI Corporation at its meetings held on 28.2.1976 as modified by its Resolutions dated 25.2.1978, 20.2.1989, 15.12.1992 and 24.2.1994 :-

Resolved that Corporation's Resolution dated 22.3.69 granting extended sickness benefit for T. B. and certain other diseases shall be replaced by the following Resolution :-

Under the powers vested in it under Section 99 of the ESI Act, 1948 and in supersession of the Resolution dated 22.3.69 on the subject of ESB, the sickness benefit granted under the ESI Act, 1948 shall be extended for persons suffering from the diseases mentioned hereunder in the manner indicated below :-

List of diseases for which ESB is paid initially for 124 days

- (1) Tuberculosis
- (2) Leprosy
- (3) Mental diseases (psychoses)
- (4) Malignant diseases
- (5) Paraplegia
- (6) Hemiplegia
- (7) Chronic congestive heart failure
- (8) Immature cataract with vision 6/60 or less in affected eye
- (9) Bronchiectasis
- (10) Lung abscess
- (11) Myocardial infarction
- (12) Dislocation and prolapse of intervertebral disc
- (13) Parkinson's disease
- (14) Aplastic anaemia
- (15) Cirrhosis of liver (The words "with ascites" deleted w. e. f. 1.1.94)
- (16) Detachment of retina
- (17) Non-union or delayed union of fracture
- (18) Empyema
- (19) Intracranial space occupying lesion
- (20) Spinal cord compression

- (21) Chronic (Simple) primary glaucoma
 - (22) Monoplegia (Resolution dated 25.2.78)
 - (23) Cardiac valvular disease with failure/complications.
 - (24) Chronic renal failure
 - (25) Hemiparesis of more than eight weeks' duration
 - (26) Post-traumatic surgical amputation of lower extremity
 - (27) More than 50% burns with infection
 - (28) Compound fracture with chronic osteomyelitis
 - (29) Chronic cor pulmonale with congestive heart failure
- (Diseases 23 to 29 added by Resolution dated 15.12.1992)

In addition to above list, in case of any rare disease or special circumstances which had not been included in the list, the Medical Commissioner may be authorised to sanction the payment of ESB for a maximum period upto 309 days depending on the merits of the case on the recommendation of the RDMC/MR/AMO or his nominee.

2. To be entitled to the ESB an insured person should have been at the beginning of a spell of sickness in which the disease is diagnosed, in continuous employment for a period of two years or more in a factory or establishment to which the benefit provisions of the Act apply.

Provided that where a person fails to qualify for ESB with reference to the first spell of sickness in which the disease is diagnosed, he shall not be debarred from qualifying the ESB in any subsequent spell of disease if he can satisfy two years continuous service with reference to that spell.

A "spell of sickness" for this purpose shall mean a period of certified incapacity commencing with a first certificate and ending with a final certificate issued in terms of the ESI (General) Regulations, 1950.

Explanation

Employment shall be held to be continuous -

- a) for period preceding 'A-Day', if the person was in continuous service as defined in section 25-B of the Industrial Disputes Act, 1947 as amended by Act 36 of 1964;
- b) for periods after 'A-Day', if the insured person has completed 4 contribution periods immediately preceding the relevant date and has paid contribution for Sickness Benefit for a period of 183 days in the 4 aforesaid contribution periods and he is eligible to claim sickness benefit atleast in one of the aforesaid 4 contribution periods. (Old para substituted by Corporations Resolution dated 20.2.1989-effective from 1.4.89)

3. The ESB shall be granted only if the insured person is otherwise entitled to ESB as above but has exhausted the sickness benefit due to him under second proviso to section 49² or is ineligible to sickness benefit in terms of section 47² of the ESI Act.

² Now Rule 55 of ESI Central Rules with effect from 1.2.1991

4. ESB shall be payable for a maximum period of 124 days initially which may be extended to 309 days in chronic suitable cases by the RMDC/MR/AMO (Chief Executive of the ESI Scheme in the State or his nominee) on the report of the specialist, where abstention from work is recommended for a total period of more than 124 days for any listed disease.

The Director General be empowered to enhance the duration of extended sickness benefit beyond the present limit of 400 days (91 days of sickness benefit plus 309 days of extended sickness benefit) to a maximum period of two years in deserving cases duly certified by a Medical Board. Facility for extension of ESB beyond the period of 400 days would be available upto the date on which the insured person attains the age of 60 years. (Earlier para 4 replaced by Corporation's Resolution dt. 24.2.94 w. e. f. 1.4.1994).

5. Immature cataract with vision 6/60 or less in the affected eye shall include mature cataract, operation of the cataract and post-operative treatment.

6. An ESB period shall consist of a period of 3 years from the date of commencement of the spell of certified incapacity for which an IP is entitled to ESB in case of tuberculosis and from the date of diagnosis in the spell in case of any other disease.

7. The period of 124 days, and where it is extended to 309 days may not be consecutive and shall exclude the days on which the I. P. is entitled to S. B. at standard benefit rate.

8. The rate of ESB during the ESB period shall be 40% more than the Standard Benefit Rate rounded to the next higher multiple of 5 paise applicable when the SB was last payable under the Act. This shall come into force with effect from 1.4.1994 and be given effect as follows : -

- (1) The benefit at enhanced rate shall be admissible in all cases of extended sickness benefit which arise on or after 1.4.1994.
- (2) The insured persons whose cases of extended sickness benefit are current as on 1.4.1994 and where they have not already exhausted extended sickness benefit shall also be entitled to the benefit at the enhanced rate with effect from 1.4.1994.
- (3) Insured persons who may not have received extended sickness benefit because of the fact that the decision regarding eligibility in their case has not been taken before 1.4.1994 shall also be eligible at enhanced rate with effect from 1.4.1994.

9. The ESB shall be payable if the sickness due to any of the diseases listed in para 1 is duly certified in accordance with the Act and the Regulations.

10. After expiry of an Extended Sickness Benefit period an I. P. may qualify afresh for ESB if he can satisfy the condition in para 2 again, provided that the condition of two years' continuous employment may be satisfied on a date following the date of termination of ESB period in cases where the incapacity due to any of the diseases shown in para 1, was continuing on the date of such termination.

11. If an insured person during the currency of an extended sickness benefit period for a particular disease, contracts any other disease for which he qualifies for Extended Sickness Benefit, the ESB for the first disease may be terminated on the date previous to the date of commencement of the spell or the date of diagnosis of the second disease, as the case may be. The insured person should qualify for new disease based on the contribution paid in the relevant four contribution periods for the second disease. (Old para substituted by Corporation's Resolution dated 20.2.1989 effective from 1.4.1989)

12. For claiming ESB in respect of any disease under para 1, the eligibility condition in para 2 will have to be satisfied independently for each disease.

13. In case where an insured person suffers from disability arising from the administration of drugs/injections, the Director General may subject to such conditions as he may like to impose, on the merits of the case, sanction ESB for a maximum period of 309 days or until the invalidity lasts, whichever is earlier in addition to the normal sickness benefit, subject to the incapacity being certified, at a rate at which ESB is payable to IP in terms of para 8. Test of two years' continuous service as applicable for the determination of entitlement of ESB referred to in para 2 above will not, however, apply in such cases.

14. In case enforcement of any particular provision of this resolution is likely to cause substantial hardship to the IP including cases falling under para 5, the Director General may on humanitarian consideration relax the same.

Resolution passed by the ESI Corporation at its meeting held on 5-12-1999

Resolved that the Corporation's Resolution dated 28-2-1976 liberalising the terms and conditions for the grant of extended sickness benefit for TB and certain other diseases shall be replaced by the following resolution:

Under the powers vested in it under Section 99 of the ESI Act, 1948 and in supersession of the Resolution dated 28-2-76 on the subject of extended sickness benefit, the sickness benefit granted under the ESI Act, 1948 shall be extended for persons suffering from the diseases mentioned hereunder:

I Infectious diseases

1. Tuberculosis
2. Leprosy
3. Chronic empyema
4. Bronchiectasis
5. Interstitial lung disease
6. AIDS

II Neoplasms

7. Malignant diseases

III Endocrine, nutritional and metabolic disorders

8. Diabetes mellitus with proliferative retinopathy/diabetic foot/nephropathy

IV Disorders of nervous system

9. Monoplegia
10. Hemiplegia
11. Paraplegia
12. Hemiparesis
13. Intracranial space occupying lesion
14. Spinal cord compression
15. Parkinson's disease
16. Myasthenia gravis/neuromuscular dystrophies

V Disease of eye

17. Immature cataract with vision 6/60 or less
18. Detachment of retina
19. Glaucoma

VI Diseases of cardiovascular system

20. Coronary artery disease:
 - a) Unstable angina
 - b) Myocardial infarction with ejection less than 45%

21. Congestive heart failure-
left
right
22. Cardiac valvular diseases with failure/complications
23. Cardiomyopathies
24. Heart disease with surgical intervention alongwith complications

VII Chest diseases

25. Chronic obstructive lung disease (COPD) with congestive heart failure (cor pulmonale)

VIII Diseases of the digestive system

26. Cirrhosis of liver with ascitis/chronic active hepatitis (“CAH”)

IX Orthopaedic diseases

27. Dislocation of vertebra/prolapse of intervertebral disc
28. Non union or delayed union of fracture
29. Post traumatic surgical amputation of lower extremity
30. Compound fracture with chronic osteomyelitis

X Psychoses

31. Sub-groups under this are listed for clarification -
 - a) Schizophrenia
 - b) Endogenous depression
 - c) Manic depressive psychosis (MDP)
 - d) Dementia

XI Others

32. More than 20% burns with infection/complication
33. Chronic renal failure
34. Reynaud’s disease/Burger’s disease.

1. In addition to the above list, Director General/Medical Commissioner are authorised to sanction extended sickness benefit for a maximum period upto 730 days in cases of rare diseases or under special circumstances which have not been included in the above list, depending on the merits of each case on the recommendations of RDMC/AMO or other authorised officers running the medical scheme.
2. To be entitled to the extended sickness benefit an insured person should have been at the beginning of a spell of sickness in which the disease is diagnosed, in continuous employment for a period of two years or more in a factory or establishment to which the benefit provisions of the Act apply.

Provided that where a person fails to qualify for extended sickness benefit with reference to the first spell of sickness in which the disease is diagnosed, he shall not be debarred from qualifying for the extended sickness benefit in any subsequent spell of disease if he can satisfy two years’ continuous service with reference to that spell.

“Spell of sickness” for this purpose shall mean a period of certified incapacity commencing with a first certificate and ending with a final certificate issued in terms of the E.S.I.(General) Regulations, 1950.

Explanation

Employment shall be held to be continuous:

- (a) For period preceding ‘A’ day, if the person was in continuous service as defined in Section 25-B of the Industrial Disputes(Amendment) Act,1947 as amended by Act 36 of 1964.
 - (b) For periods after ‘A’ day, if the insured person has completed 4 contribution periods immediately preceding the relevant date and has paid contribution for sickness benefit for a period of 156 days in the 4 aforesaid contribution periods and he is eligible to claim sickness benefit atleast in one of the aforesaid 4 contribution periods.
 - (c) A person in insurable employment may go out of coverage due to enhancement of wages and may be brought under coverage subsequently. The period of interruption should also be taken as insurable employment for the purpose of the term “continuous service”.
3. The extended sickness benefit shall be granted only if the insured person is otherwise entitled to extended sickness benefit as above but has exhausted the sickness benefit due to him under second proviso to Rule 55(1) or is ineligible to sickness benefit in terms of Rule 55(1) of the ESI (Central) Rules, 1950.
 4. Extended sickness benefit shall be payable for a maximum period of 124 days initially which may be extended upto 309 days in suitable chronic cases by RDMC/MR/AMO/Chief Executive of the ESI Scheme in the state or his nominee on the report of the specialist where abstention from work is recommended for a total period for more than 124 days for any listed disease.
 5. The Regional Director/Joint Director (I/c) may enhance the duration of extended sickness benefit beyond the present limit of 400 days to a maximum period of two years in deserving cases duly certified by a medical board on the recommendation of MR and RDMC. Facility for extension of extended sickness benefit beyond the period of 400 days would be available upto the date on which the insured person attains the age of 60 years and would include sickness benefit for the disease for which extended sickness benefit payment has been sanctioned.
 6. Immature cataract with vision 6/60 or less in the affected eye shall include mature cataract, operation of the cataract and the post operative treatment.
 7. An extended sickness benefit period shall consist of a period of 3 years from the date of commencement of the spell of certified incapacity for which an insured person is entitled to extended sickness benefit in case of tuberculosis and from the date of diagnosis in the spell in case of any other disease.
 8. The period of 124 days, and where it is extended to 309 days or two years may not be consecutive and shall exclude the days on which the insured person is entitled to sickness benefit at standard benefit rate.
 9. The rate of extended sickness benefit during the extended sickness benefit period shall be 40% more than standard benefit rate rounded to the next higher multiple of 5 paise applicable when the sickness benefit was last payable under the Act.

10. The extended sickness benefit shall be payable if the sickness is due to any of the diseases listed in Para 1, as duly certified in accordance with the Act and Regulations.
11. After expiry of an extended sickness benefit period an IP may qualify afresh for extended sickness benefit if he can satisfy the condition in para 2 again provided the condition of two years' continuous employment is satisfied on a date following the date of termination of extended sickness benefit period in cases where the incapacity due to any of the diseases shown in para 1 was continuing on the date of such termination.
12. If an insured person during the currency of an extended sickness benefit period for a particular disease, contracts any other disease for which he qualifies for extended sickness benefit, the extended sickness benefit for the first disease may be terminated on the date previous to the date of commencement of the spell or the date of diagnosis of the second disease as the case may be. The insured person should qualify for new disease based on the contributions paid in the relevant four contribution periods for the second disease.
13. For claiming extended sickness benefit in respect of any disease under para 1, the eligibility condition in para 2 will have to be satisfied independently for each disease.
14. In case where an insured person suffers from disability arising from the administration of drugs/injections, the Director General may, subject to such conditions as he may like to impose depending on the merits of the case, sanction extended sickness benefit for a maximum period of 309 days extended upto 2 years or until the invalidity lasts, whichever is earlier in addition to the normal sickness benefit, subject to the incapacity being certified, at a rate at which extended sickness benefit is payable to the insured person in terms of para 9. Test of two years' continuous service as applicable for the determination of entitlement of extended sickness benefit referred to in para 2 above will not, however, apply in such cases.
15. In case enforcement of any particular provision of this Resolution is likely to cause substantial hardship to the insured person including cases falling under para 6, the Director General/Insurance Commissioner may, on humanitarian considerations, relax the same.
16. The Resolution would be effective from 1.1.2000 and shall be given effect to as follows:
 - i) The insured persons suffering from any of the diseases included in the Corporation Resolution dated 28.2.1976 and who were eligible for ESB in respect of a spell which commenced before the above date shall continue to be eligible for ESB for 124/309/730 days as the case may be, during the ESB period for 3 years in accordance with the old Resolution dated 28.2.76 till the spell is terminated.
 - ii) All past cases not eligible in terms of Corporation Resolution dated 28.2.76 shall not be reopened.

Section 25-B of Industrial Disputes Act 1947

Definition of continuous service

25B. For the purpose of this chapter,-

- (1) a workman shall be said to be in continuous service for a period if he is, for that period, in uninterrupted service, including service which may be interrupted on account of sickness or authorised leave or an accident or a strike which is not illegal, or a lock-out or a cessation of work which is not due to any fault on the part of the workman;
- (2) Where a workman is not in continuous service within the meaning of clause (1) for a period of one year or six months, he shall be deemed to be in continuous service under an employer --
 - (a) for a period of one year, if the workman, during a period of twelve calendar months preceding the date with reference to which calculation is to be made, has actually worked under the employer for not less than--
 - (i) one hundred and ninety days in the case of a workman employed below ground in a mine; and
 - (ii) two hundred and forty days, in any other case;
 - (b) for a period of six months, if the workman, during a period of six calendar months preceding the date with reference to which calculation is to be made, has actually worked under the employer for not less than--
 - (i) ninety-five days, in the case of a workman employed below ground in a mine; and
 - (ii) one hundred and twenty days, in any other case.

Explanation – For the purposes of clause (2), the number of days on which a workman has actually worked under an employer shall include the days on which –

- (i) he has been laid-off under an agreement or as permitted by standing orders made under the Industrial Employment (Standing Orders) Act, 1946 (20 or 1946), or under this Act or under any other law applicable to the industrial establishment;
- (ii) he has been on leave with full wages, earned in the previous years.
- (iii) he has been absent due to temporary disablement caused by accident arising out of and in the course of his employment; and
- (iv) in the case of a female, she has been on maternity leave; so however, that the total period of such maternity leave does not exceed twelve weeks.

-
- Coded as malignant unless specified as benign

CHAPTER VIII

EXTENDED SICKNESS BENEFIT PROCEDURE

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CHAPTER VIII

EXTENDED SICKNESS BENEFIT PROCEDURE

Confirmation of ESB disease by specialist

P.8.1. It is the IMO who would first suspect the presence of a disease which needs specialist consultation and treatment and is likely to take long before it responds to treatment. He would initially issue medical certificates indicating a non-specific classification of the disease. Once the specialist confirms that the insured person is suffering from a disease for which ESB is payable, the IMO will issue the next certificate indicating the exact diagnosis underlined in red ink. He would also fill in form ESIC-MED-8 (copy at Annexure 'A') in duplicate, and send one copy to the Branch Office while keeping the other as office copy.

P.8.2. In case ESIC-MED-8 is received and the diagnosis given is categorical and clear, there is no need for confirmation of the same by the Medical Referee. Where ESIC-MED-8 is not received or where specialist's opinion is not available, it will be necessary to obtain SSMC / SMC / Medical Referee's confirmation of the diagnosis before initiating action for payment of ESB.

P.8.3. Sometimes, even if ESIC-MED-8 is available, it becomes difficult for the Branch Office to ascertain from the nomenclature given on the ESIC-MED-8 or on the medical certificate whether the same entitles an insured person to ESB. For such cases, confirmation may be obtained from the SSMC / SMC / MR whoever is available. Separate confirmation by Medical Referee also will not be required where an insured person submits a certificate for in-patient treatment issued by a government/district/ESI hospital or one having reserved beds for ESI patients provided the certificate gives clear diagnosis showing the disease for which ESB is payable and payment of ESB, if admissible and due, can be made by the Branch Manager.

ESB rate card-ESB diary

P.8.4. On receipt of the intermediate certificate in which diagnosis entitling ESB has been written in red ink, the claims clerk will prepare the shuttle card on ESIC-47. He will also make entries in the separate diary for ESB cases in form ESIC-95 (copy at Annexure 'B') and obtain Manager's approval on rate prepared on ESIC-47. A copy of the ESIC-47 is at Annexure 'C'. Certain important matters regarding preparation of ESIC-47 are explained below : -

Column 5(a)-A-Day for the area/factory/establishment

If the factory/establishment is covered since A-Day for the area, enter the same here and also state "factory/establishment covered since A-Day". If factory/establishment has been covered after A-Day for the area, mention 'A-Day' for the factory/establishment and also furnish particulars of "A-Day for the Area....." separately.

Column 7-eligibility details of 2 years' continuous service

- (a) In case of an insured person who has not completed 4 contribution periods before the start of relevant spell of sickness:

In the first year, mention the dates covering one previous year starting from date corresponding to the date of start of spell of sickness upto the date preceding it. Proceeding backward, mention the earlier year's dates against "II year". As an illustration, for a person who has not completed 4 contribution periods before 21.1.09 which is the date of start of the spell of his sickness, the periods to be entered will be from 21.1.08 to 20.1.09 in the first year and 21.1.07 to 20.1.08 in the second year.

All other columns are self-evident and must be filled in completely and accurately.

Continuous service

P.8.5. For those persons who have not completed 4 contribution periods before the date of start of the relevant spell of sickness, it will be necessary to have their record of continuous service checked from the records of the factory/establishment to see whether they have put in a minimum of 240 days' service in the covered factory/establishment in accordance with the provisions of section 25-B of the Industrial Disputes Act, 1947 and for this purpose an official of the Branch Office not below the rank of Upper Division Clerk may be deputed immediately. Employment in some other unit covered under the ESI Scheme may also be probed. It is not necessary to issue an advance notice to the employer to keep the information ready. The Branch Office official will personally take ESIC-126 (copy at Annexure 'D') and verify the fact of continuous service from the records of the factory/establishment on the spot and get the necessary certificate from the employer. He will also record a certificate of verification under his dated signature with designation. The form ESIC-47 prepared in respect of such an insured person will also contain particulars of contribution periods expiring before the relevant date.

Contribution record verification

P.8.6. In respect of each of the contribution periods expiring before the relevant date eligibility to sickness benefit has to be determined from the relevant return of contributions with the Branch Office. If any of these returns is not available, ESIC-71 may be issued. But it is incumbent upon the Branch Manager to get the particulars of each ESIC-71 verified with reference to original records of the employer by the Branch Office official not below the rank of an Upper Division Clerk. A certificate of verification of the employer's record will be duly recorded in ESIC-47 and in the proforma submitted to Headquarters Office (Annexure 'G') for seeking relaxation to the contributory condition envisaged in para 15 of Corporation's Resolution dated 5.12.1999. Where it becomes necessary to do so in a particular case, the certificate of verification will be duly signed in full by the verifying official who would also write his name in full and designation below it. In cases where the concerned employer is in partial or total default with regard to submission of return of contributions, this fact should be clearly recorded in the ESB diary (ESIC-95) as well as in ESIC-47/proforma for seeking relaxation.

P.8.7. It is to be borne in mind by all at the Branch Office that action for determining title to ESB must be completed by the Branch Office within a week of the receipt of the certificate bearing diagnosis of the disease for which ESB is admissible.

ESIC-48

P.8.8. The Branch Office will also prepare ESIC-48(specimen at Annexure 'E') in triplicate, indicating the date of commencement of the spell of sickness in case of tuberculosis and the date of diagnosis in case of other diseases, as also the last date three years later corresponding to these dates respectively upto which medical benefit would be admissible to the insured person. As an illustration, if the date of commencement/diagnosis of an insured person is say 15.6.09 the date upto which medical care would be admissible to him, would be 14.6.12. The ESIC-48 in triplicate would be sent to the Regional Office/designated Branch Office within 10 days after the end of the month with a monthly statement (specimen at Annexure 'F'). In panel areas two copies of ESIC-48 will be sent by the Regional Office/designated Branch Office to the Administrative Medical Officer who will send one copy to the concerned Insurance Medical Practitioner. In service areas, the copy meant for the ESI Dispensary will be sent direct to it by the Regional Office/designated Branch Office while one copy will be sent to the Administrative Medical Officer. Regional Office/designated Branch Office will also make entries simultaneously in ESIC-38 register in red ink, stating : "ESB case entitlement upto.....".

Relaxation Action

P.8.9. Normally, the following conditions should be satisfied before an IP can be made eligible to extended sickness benefit:-

- (a) The beneficiary should be an insured person on the date of commencement of spell of extended sickness benefit.
- (b) At the beginning of the spell, he should be in continuous employment for a period of 2 years or more in a covered factory or establishment. The term “continuous employment” means that the insured person should have completed 4 contribution periods immediately preceding the spell of sickness.
- (c) The contribution should have been paid/payable for 156 days in the above-said 4 contribution periods in respect of the insured person.
- (d) The insured person should have been eligible to claim sickness benefit at least in one of these 4 contribution periods.

P.8.10. However, *vide* para L.8.27 of ESB Law, Director General/Insurance Commissioner has been empowered by the Corporation to relax on humanitarian grounds, any of the conditions laid down in its Resolution that is likely to cause substantial hardship to an insured person. According to Explanation (b) under para 2 of the Corporation’s Resolution, all the conditions as above must be normally satisfied by persons claiming ESB. But, two types of persons may not fulfil the condition (b) or (c) or (d) of preceding para:

- (1) Persons who went out of coverage and were re-covered upon the raising of monthly wage-limit for coverage. Their cases were hitherto not covered under para 2(b) of Resolution above quoted. But by virtue of Corporation’s Resolution dated 5.12.1999, effective from 1.1.2000, these cases are now covered by Explanation (c) under para 2 of the said Resolution (*vide* Annexure ‘B’ to ESB Law).
- (2) This leaves us with two other types of cases which may deserve relaxation:-
 - (i) Those who have not completed two years’ service but have paid 156 days’ contribution and have also qualified for SB in one of the contribution periods.
 - (ii) Those who have completed two years of service and also paid 156 days’ contribution but have not qualified for SB in any contribution period.

To avoid delay and to mitigate hardship to such IP’s, Director General has delegated his power of relaxation as aforesaid, to the Regional Director/ Director/ Joint Director Incharge. Cases of the nature described above, needing relaxation, may henceforth be submitted to Regional Director/ Director/ Joint Director Incharge for relaxation in the modified proforma at Annexure G.

Payment of ESB upto 124 days

P.8.11. Ordinary sickness benefit, if admissible, will continue to be paid by the Branch Office in the usual manner on the strength of intermediate certificates received in the current spell, until the insured person either exhausts the same or on the start of the new benefit period, is found ineligible for sickness benefit. On the happening of either event and subject to issue of incapacity references and, based on the nature of replies thereto, the payment of ESB can commence so as to continue for a period of 124 days on the basis of ESIC-Med-8 or confirmation by SSMC / SMC / MR as per para P.8.2 and medical certificates showing the diagnosis of the same disease for which the insured person became entitled to ESB. In most

cases, the ESB rate would be available and payment of ESB should commence without delay. If relaxation of any condition has been sought in any case, the same should be available by the time payment of ESB is to commence, and this can be achieved through timely action for preparation of ESB rate. Timely action, therefore, must be ensured.

ESB rate preparation

P.8.12. The ESB rate will be prepared in the manner described in paragraph L.8.21.2 of the ESB Law and will be reviewed at the beginning of each benefit period. Entry of the ESB rate after it is certified by Manager will be made in red ink in the top left hand corner of the ledger sheet with a remark 'ESB' clearly indicated. The claims clerk, checker and Manager will initial each entry with date. ESIC-47 will be filed in Ins. No. order in a separate file. When the insured person comes for payment of ESB, the usual procedure of diarising the certificates, application of Reg. 64, obtaining the claim, its checking, passing and payment as in the case of sickness benefit will be followed but entries of ESB will be made in red ink and the days paid will also be counted separately and entered in red ink in the ledger, so as to facilitate their counting separately from days of sickness benefit.

Incapacity references

P.8.13. Periodical routine incapacity reference of insured persons suffering from the diseases named below should be made by the Branch Office at intervals of 3 months :-

- (1) Tuberculosis
- (2) Malignant disease (cancer)
- (3) Paraplegia
- (4) Haemiplegia
- (5) Delayed/non-union of fracture
- (6) Leprosy
- (7) Hemiparesis
- (8) Cardiac valvular diseases with failure/complication
- (9) Chronic obstructive lung disease (COPD) with congestive heart failure (cor pulmonale)
- (10) Post traumatic surgical amputation of lower extremity
- (11) Compound fracture with chronic osteomyelitis
- (12) Chronic renal failure

Incapacity reference of insured persons suffering from other diseases for which ESB is payable should be made at intervals of 28 days.

P.8.14. For procedure regarding restoration or otherwise of ESB in case of failure of insured persons to attend for MR's examination, please see Chapter XI.

Extension beyond 124 days

P.8.15. For extension of ESB beyond 124 days, the case papers of the insured person will be submitted by the Branch Manager for review to (a) Medical Referee or (b) SSMC / SMC or (c) Administrative Medical Officer or Chief Executive incharge of the Scheme in order of preference, in the form at Annexure 'H'. The IMO from whom the insured person is taking treatment and certificate would have referred his case to the specialist in the mean time for obtaining his expert opinion for the line of treatment as well as for continuing the issue of certificates of incapacity. Before referring the insured person to decide question of extension beyond 124 days, the IMO may be requested to provide the latest information on the insured person's condition and the reply received may be attached with the case papers.

P.8.16. Under no circumstances should payment of ESB be continued beyond 124 days without the recommendation of the Medical Referee/SSMC / SMC /AMO or his nominee. However, in order to avoid delay in resumption of payment of ESB beyond 124 days the Branch Office should refer the case papers about 24 days before expiry of the period of 124 days. It may be noted that this reference will be made strictly in the form at Annexure 'H' and not on RM-1 which is meant for routine incapacity references.

P.8.17. Payment of ESB made for periods beyond 124 days without the recommendation of SSMC / SMC / MR/AMO or his nominee, as the case may be, is deemed as wrong payment for which Branch Manager, claim clerk etc. will be held responsible.

P.8.18. Payment of ESB beyond 124 days may be continued (or discontinued, as the case may be) in the light of recommendation received in form at Annexure 'H'. Once the extension has been recommended, there is no need again to refer the case in form at Annexure 'H' and payment of ESB can continue upto a period of 309 days subject to issue of routine incapacity references in the manner described above.

Extension beyond 309 days

P.8.19. Para 5 of Corporation's Resolution dated 5.12.1999 vide Annexure 'B' of ESB Law, empowers Regional Director / Jt. Director I/c to enhance the duration of ESB beyond the normal limit of 309 days (exclusive of a maximum period of 91 days availed as sickness benefit) to a maximum period of 2 years (inclusive of 91 days of sickness benefit and 309 days of ESB availed) duly certified, on the recommendations of the Medical Board, subject to the condition that this further period of ESB beyond 309 days is limited to the date on which IP reaches the age of 60 years.

P.8.20. Insured persons suffering from long-term diseases make frequent visits to the Branch Office for receiving extended sickness benefit. In many a case, an insured person suffering from a long-term disease and availing of extended sickness benefit (as well as sickness benefit whenever eligible) for a maximum period of 309 days may not get well enough to rejoin duty and medical certificates in respect of his sickness may have continued to be received in the Branch Office. The Branch Manager should review such cases and, if found deserving, he should get his papers prepared in Part 'A' of the proforma at Annexure 'I' and forward the same alongwith the required enclosures to the SSMC / SMC / Medical Referee as early as feasible but preferably by about a month before the likely date of the exhaustion of normal extended sickness benefit. If related papers are complete in all respects, SSMC / SMC / Medical Referee will have no difficulty in giving his opinion in Part 'B' of the proforma and he will forward the same to the Benefit Branch at Regional Office/ Sub Regional Office which would have already received similar papers from other Branch Offices and Regional Office/ Sub Regional Office shall promptly call a meeting of the Medical Board (if Medical Board is not meeting regularly on a fixed date), to seek their recommendation/opinion in part 'C' of the proforma.

P.8.21. Medical Board's recommendation when received will be promptly referred by Regional Office alongwith all the enclosures to SSMC / SMC for his opinion/recommendation to be recorded in part 'D' of the proforma (Annexure 'I'). Based on Medical Board/SSMC's/SMC's opinion/recommendation, these papers will be put up to Regional Director for his sanction which, on receipt, will be conveyed

without delay to the Branch Office concerned in the proforma suggested in para P.8.26 or otherwise as may be found suitable.

P.8.22. In cases involving payment of ESB beyond 309 days, the Branch Manager, while resuming payment of ESB for further period shall bear in mind that the number of days of sickness benefit, if availed for this disease, after exhausting 309 days of ESB, will also be counted to make up the total to 2 years (730 days), but not the days of sickness benefit availed on account of some other diseases.

P.8.23. Further, the number of days for which extension of ESB is to be allowed will be limited to the date on which –

- (a) IP/IW reaches the aggregate period of 2 years (730 days) counted in the manner stated in the previous para, or
- (b) Sanction expires, or
- (c) IP/IW completes 60 years of age, or
- (d) ESB period of 3 years terminates or is prematurely terminated, or
- (e) IP dies,

whichever happens the earliest. While making entries in the top left hand corner of the IP/IW's ledger sheet in red ink, above facts should also be recorded and particularly (b), (c) & (d) above and attested by claims clerk, checker and Manager.

P.8.24. In case of alternative (b) above, if the IP continues to submit certificates beyond the last date of the period for which sanction has been conveyed, fresh sanction, in case IP/IW has not yet reached the age of 60 years, will have to be solicited for which reference may be made by the Branch Manager in the manner described in the foregoing paragraphs.

Cases requiring sanction

P.8.25. Regional Office / Sub Regional Office will continue to refer other cases requiring Hqrs. sanction under para 1 and explanation (b) under para 2 of the Corporation's Resolution. To keep a watch over the progress of these cases as well as those cases where Regional Director/ Joint Director i/c is the competent authority, Regional Office/ Sub Regional Office will maintain a register as in the proforma suggested below:-

1. Name of Branch Office
2. Name of IP/IW
3. Insurance Number
4. Name of long-term disease from which suffering
5. Para No. of Corporation's Resolution under which reference made, i.e., para 2(b)/2(c)/14/15.
6. Authority competent to sanction
7. Dates of –
 - (a) Receipt of papers from B.O./MR/RDMC
 - (b) Despatch to Hqrs. (if required)

(c) Receipt from Hqrs.

(d) Despatch to Branch Office

8. Period for which sanction/relaxation received from RD/Hqrs. From to

9. (a) Date of birth admitted as per documentary evidence.

(b) In absence of (a), date of birth as determined by Medical Board.

(c) Date on which IP will complete 60 years of age

10. Date upto which further ESB payable

11. Dated initials

(a) Dealing Assistant

(b) Head Clerk/Superintendent

Those cases where Hqrs. Sanction is required but decision is not received within a month of despatch of papers to Hqrs., will be pursued through reminders/D. O. reminders/e-mail. The Branch Manager on his part will also keep on reminding Regional Office at fortnightly intervals until decision regarding sanction/relaxation is received.

P.8.26. Promptly on receipt of decision regarding sanction/relaxation, Benefit Branch will make entries in the register and inform the Branch Office accordingly, giving full particulars in a letter, as per proforma suggested below:-

To

The Manager
Branch Office,
ESI Corporation
.....

Subject:- Payment of ESB – sanction/relaxation by Hqrs./Regional Director/ Joint Director i/c –
case of Sh./Smt. Ins. No

Sir,

I am directed to convey the sanction of to the payment of ESB in respect of IP/IW named above, as per particulars given below:-

1. Reference para No. of Corporation's Resolution
2. Nature of disease
3. Nature of sanction/relaxation
4. Period for which ESB sanctioned from to
5. Date of birth admitted (in case of extension of ESB beyond 309 days)

6. Name of sanctioning authority DG/IC/MC/RD

Yours faithfully,

Asst.Director/Dy.Director(B)

Copy To: Asst. Director/Dy.Director(F) for information and necessary action.

Asst.Director/Dy.Director(B)

P.8.27. Copies of Regional Office/ Sub Regional Office communication shall be forwarded to the Finance Department of Regional Office/ Sub Regional Office. The audit party will conduct post-audit of all such cases during its next visit to the Branch Office. The Regional Office/ Sub Regional Office communication when received in the Branch Office shall be filed with the first payment docket after making entries in the Branch Office diary and ledger sheet.

Rare disease

P.8.28. Under para 1 of Corporation's Resolutions dated 5.12.1999, DG/MC is empowered to sanction payment of ESB to an insured person suffering from a rare disease other than the diseases mentioned in the Resolutions [See Annexure 'B' of ESB Law]. The Branch Manager would, in his daily routine duties of passing claims etc., come across some persons who continue to suffer their ailment despite all the treatment and rest admissible under the Scheme. Such insured persons may be driven to despair specially if they have exhausted their sickness benefit and are in extreme indigent circumstances. It is in circumstances such as these that the Branch Manager should inquire fully into an insured person's circumstances, consult the treating IMO informally about the nature of his ailment and chances of his recovery, whereafter he should refer the case to Medical Referee/AMO or his nominee by filling in part A of the proforma at Annexure 'I' with necessary modifications. The SMC/Medical Referee will record his recommendations in Part B of this proforma and forward it to the SMC who, after recording his recommendations in Part D, will forward it by registered post to Medical Commissioner, ESI Corporation, C.I.G.Marg, New Delhi – 110 002, under intimation to Regional Office (Benefit Branch). Part C of this form will be left blank and crossed. Branch Manager will also keep RO informed about the reference of such a case to SMC/Medical Referee.

P.8.29. If the Director General/Medical Commissioner accepts the recommendations, he will sanction the payment of ESB and would also specify the period of payment not exceeding 730 days. The papers will then be forwarded to Regional Office/ Sub Regional Office who will inform the Branch Manager in the following proforma:-

To

The Manager,
Branch Office,
ESI Corporation,

Sub:- Payment of ESB for 'Rare' disease – sanctioned by Director General/
Medical Commissioner – Case of IP/IW.....Insurance No.....

Sir,

I am directed to convey the sanction of the Director General/Medical Commissioner to the payment of ESB in respect of IP/IW named above for the rare disease he/she has been suffering from, as per particulars given below:-

- (1) ESB period : from _____ to _____
- (2) Name of disease
- (3) Period (with dates) for which ESB sanctioned: from _____ to _____

Yours faithfully,

Asst. Director/Dy. Director

Copy to Asst. Director/Dy. Director(F) for information and necessary action.

Copy of this sanction memo shall be endorsed to Finance Department of Regional Office for post-audit in the manner stated in para P.8.27 above. The Branch Manager will cause an entry including the disease and the period with dates made in red ink in the top left corner of the ledger sheet of the IP/IW and attested with dated initials of claims clerk, checker and Manager. The sanction will be filed alongwith the first payment docket. Action for issue of ESIC-48 will also be taken in the manner detailed in para P.8.8 above.

Points to be borne in mind while making reference

P.8.30. For prompt action at every level and to prevent back references being made resulting in delay and hardship to the suffering insured person, it should be ensured at all levels as under:-

- (1) All the treatment papers, complete and upto date and zerox copies enclosed with each case should be attested and submitted.
- (2) ESIC-47 and certificate of eligibility should be enclosed.
- (3) Where extension of ESB is required beyond 309 days, Medical Board should clearly state in column 10 of their report in Part C of proforma at Annexure 'I', the period with dates for which it is recommended.
- (4) Request of IP/dependant should be enclosed.
- (5) Brief chronological history alongwith the present position must be given on a separate sheet.
- (6) All the complete up-to-date treatment papers should be submitted.
- (7) Any other information relevant to the case should be enclosed.

Record of ESB cases

P.8.31. Records pertaining to each ESB case, viz., specialist's report, Medical Referee's report, ESIC-71 forms etc., may be kept together in a file for easy availability and production before the Regional Director.

Return of terminated cases

P.8.32. When the last instalment of ESB is paid, the following information will be posted in a register which will have a few sheets allotted for cases of tuberculosis and another few sheets allotted for all other diseases combined : -

- (1) Serial Number
- (2) Name of insured person
- (3) Insurance number
- (4) Total period of certified incapacity
- (5) Total number of SB days
- (6) Total amount of SB paid
- (7) Total number of ESB days
- (8) Total amount of ESB paid
- (9) How terminated : whether by recovery/exhaustion/death/other causes (specify)

While the above columns will be common for both portions, an additional column, nature of disease may be added as column (10) in the pages allotted for other diseases. The information so collected will be incorporated in the relevant columns of ESIC-27 (monthly return)* sent by the Branch Office to the Regional Office/ Sub Regional Office.

Diary of referred cases

P.8.33. The Branch Manager will maintain a simple diary of all cases referred to Regional Office/ Sub Regional Office/Hqrs. under various paras, i. e., para 1 (Rare disease), para 5 (Extension beyond 309 days), para 2(b) (In the light of para 15 of Corporation's new Resolution at Annexure 'B' of ESB Law). Cases covered under para 2(c) i. e., those who have been covered again under the Scheme on raising of monthly wage limit for coverage will also be entered in this register, in the proforma suggested below:-

- (1) Serial No.
- (2) Name of IP/IW
- (3) Insurance No.
- (4) Nature of disease
- (5) Date of reference

*Its new number is MISLO-03 and its proforma is given in "Revised Management Information System i. e., Periodical Returns to be submitted by the Branch Offices to the Regional Offices", copies of which were supplied to all Branch Offices.

- (6) To whom
- (7) Relevant para no. of Corporation's Resolution
- (8) Dated initials of DA/HC/BM
- (9) Date of receipt of sanction
- (10) Period (with dates) for which sanction received
- (11) Date of issue of ESIC-48 to IMO/AMO/RO/designated BO
- (12) Initials of DA/HC/BM
- (13) Date of fresh reference to RO, if any
- (14) Reasons therefor
- (15) Dated initials of DA/HC/BM

EMPLOYEES' STATE INSURANCE CORPORATION

**For insured persons suffering from a disease for
which ESB is payable**

Stamp of dispensary/Clinic

Name of insured person

Insurance Number

Occupation

Place of work

Residential address

1. History of case :
2. Previous illness :
3. Present diagnosis :
4. Specialist's report in detail dated.....
5. Opinion of the specialist whether patient should receive dispensary/domiciliary/hospital treatment :
6. The patient requires/does not require abstention from work
7. Date of next reference to specialist for check-up.....

Date.....

Signature of IMO
with rubber stamp

BRANCH OFFICE DIARY OF EXTENDED SICKNESS BENEFIT CASES

S. No.	Name of the insured person	Ins. No.	Name of Employer	Particulars of the 1 st certificate containing diagnosis of relevant disease			Date of commencement of the spell	Date of issue of letter to the employer if necessary	Date of receipt of certificate of continuous employment from the employer	Date of preparation of ESIC-47 at Branch Office
				Date Of issue	Date of receipt at the Branch Office	Exact diagnosis in brief				
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.

Date on which reference made to Med. Ref./specialist for confirmation of disease	Disease	Date on which ESB disease confirmed by Med. Ref./ specialist/ SMC/AMO	Title to eligibility		Date of despatch of ESIC-48 to R. O.	Initials of DA/checker/Manager	Remarks
			Whether eligible for ESB	Date upto which medical benefit is admissible under Reg. 103-A			
12	13	14	15	16	17	18	19

ESB Period expires on Name of the B. O.....

EMPLOYEES' STATE INSURANCE CORPORATION
E. S. B. RATE CARD

Ref. No. in ESIC-95	
1.	Name of the I. P..... Ins. No..... Ref. Ledger Page No.....
2.	Name of Dispensary.....Code No. of I. M. P.....
3.	E. S. B. Disease from which suffering..... Date of first certificate in the spell Date of diagnosis in cases other than TB.....
4.	Whether diagnosis confirmed by Medical Referee/RDMC/Specialist.....
5.	(a) A-Day for area/factory/establishment..... (b) Date of IP's entry in insurable employment.....
6.	Last day on which S. B. was or would be admissible and the rate thereof.....
7.	Eligibility details of 2 years' continuous service (a) In case of an IP who has not completed 4 contribution periods before the start of spell of relevant sickness No. of days worked as described in Sec. 25 B of Industrial Disputes Act, 1947..... 1 st year from.....to..... 2 nd year from.....to..... (b) Contributory particulars of preceding four contribution periods : -

S. No.	Contribution period ending.....	No. of days for which contribution paid/payable	If eligible, whether certified on ESIC-71/RC	Whether qualified for SB (Yes/No)	Remarks
1.					
2.					
3.					
4.					
Total					

8. Details of any other ESB period current.

Disease.....ESB period.....

Date of termination of ESB spell.....

9. Is the beneficiary an insured person on the date of commencement of spell of long-term sickness?

10. How have you satisfied yourself in support of your answer in Col. 9?

11. Whether eligible to ESB Eligible Not Eligible

12. ESB Rate (payable) approved Rs.....(Rupees).....

Name of clerk and dated signature

Name of Manager and Dated signature

Name of Checker and dated signature

Rubber Stamp

Ref. : ESIC-48 issued.....

Ref. :Intimation to Regional Office.....

Signature of claims clerk and checker

Signature of Manager

BRANCH OFFICE.....

EMPLOYEES' STATE INSURANCE CORPORATION

No.....

Date.....

M/s.....

.....

.....

Subject: Certificate of continuous service in respect of Shri.....
Ins. No..... in connection with grant of extended medical and
sickness benefits

Dear Sir,

I have to state that with a view to determine the title of the above mentioned insured person to extended medical and cash benefits under the Employees' State Insurance Act, it is necessary to know the period of his employment in a factory/establishment to which the Employees' State Insurance Act applies. I have, therefore, to request you to kindly fill up the following certificate of continuous service and keep it ready alongwith relevant records for spot verification by one of the officials of this office who will be visiting your factory on This letter may please be returned to him after filling up the certificate.

Yours faithfully,

Manager,
Branch Office.....

CERTIFICATE OF CONTINUOUS SERVICE

Certificate of continuous service in respect of Shri/Smt.....
S/W/D of

Certified that in accordance with the definition of the term ‘continuous service’ as contained in Section 25-B of the Industrial Disputes Act, 1947, as amended, the date from which the above mentioned insured person has been in continuous employment with us prior to* is

2. The insured person also claims to have been in service in other factories/establishments to which Employees’ State Insurance Act applies as follows : -

Name of the factory	Code No. (if known)	Period of Service		Documentary evidence, if any, produced by insured person
		From	To	

Signature.....

Designation.....

(Rubber stamp containing name & code number of employer)

*Note 1: It should be ensured that insured person was in continuous service for 2 years before the date of commencement of the spell of the present sickness, i. e., from.....

Note 2: The following days shall be included as working days for the purpose in a year :-

- (i) Period for which he has been laid off under an agreement or as permitted by the Standing Orders made under the Industrial Employment (Standing Orders) Act, 1946 or under the Industrial Disputes Act, 1947 or under any other law applicable to the industrial establishment.
- (ii) Period for which he has been on leave with full wages earned in the previous year.
- (iii) The number of days (with dates) he has been absent due to temporary disablement arising out of and in the course of his employment.
- (iv) In the case of a female, the period for which she has been on maternity leave so, however, that the total period of such maternity leave does not exceed 12 weeks.

ESIC-48

BRANCH OFFICE -----
EMPLOYEES' STATE INSURANCE CORPORATION

Intimation for extended medical benefit

1. Name of the insured person _____
2. Insurance No. _____ Employer's Code No. _____
Date of entry _____
3. Date of commencement of ESB period * _____
4. The insured person will continue to be entitled to medical benefit for a period of three years from the date mentioned in item 3 i.e. upto _____.

MANAGER

*Mention here the date of start of spell of sickness in which TB is diagnosed or the date of diagnosis in case of any other long-term disease for which ESB is payable.

BRANCH OFFICE.....

EMPLOYEES' STATE INSURANCE CORPORATION

No.

The Regional Director,

.....
.....

Sub: Statement for the month ofin respect of
ESB cases admitted at the Branch Office.

Sir,

I have to inform you that title to extended sickness benefit of the following insured persons has been determined and their particulars are furnished in the statement as below.

Necessary entries may please be made in ESIC-38 register. Forms ESIC-48 (in triplicate) are enclosed.

Yours faithfully,

Manager
Branch Office.....

Sr. No.	Name	Ins. No.	Nature of disease diagnosed	Date of commencement of spell in which TB was diagnosed	Date of diagnosis for diseases other than tuberculosis	Eligibility position during relevant 4 cont. periods
1	2	3	4	5	6	7

If not found eligible whether relaxation obtained and if so, whether eligibility confirmed.	Date of termination of ESB Period	Name of dispensary/ Code No. of IMP	Remarks
8	9	10	11

BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

**Proforma for relaxation of para 2 of ESIC's Resolution Dated 5.12.1999,
as amended, in the light of para 15 thereof**

1. Name of IP
2. Ins. No.
3. His/Her age (preferably date of birth)
4. Date of commencement of spell for which ESB is claimed
5. Date of receipt of certificate indicating diagnosis at Branch Office
6. (a) Date of diagnosis
(b) Nature of disease
7. A-Day for the area
8. If factory/establishment covered after A-Day for the area,
 - (1) Date of its coverage
 - (2) Whether covered u/s 1(3) or 1(5)
9. (a) If IP had gone out of coverage as an 'employee' date upto which he was last covered as an 'employee'
10. (a) Particulars of continuous service rendered in terms of Section 25B of Industrial Disputes Act, 1947: -
 1. From.....To.....Days worked.....
 2. From.....To.....Days worked.....

(b) Contributory record before date of commencement of spell in which ESB is claimed

Contribution Period		No. of days for which contributions paid/payable	Whether qualified for SB	Source of information: RC or ESIC-71	Remarks
From	To				
(1)	(2)	(3)	(4)	(5)	(6)

11. Date from which ESB would be payable if relaxation is allowed

12. On commencement of the spell of long term sickness during the benefit period,
- (a) Is/was he/she an 'insured person'?
 - (b) Is/was he/she entitled to medical benefit?
13. (a) Has the insured person availed of any such relaxation for this disease before?
- (b) If so, particulars thereof
14. Certified that (i) the above particulars have been verified personally by me, (ii) the diagnosis has been confirmed as per the instructions on the subject, (iii) particulars of ESIC-71 wherever obtained have been duly verified from the employer's records and that the insured person is actually and not undeservedly entitled to medical benefit as indicated in Col. 12(b) above.
- Name and full signature of official verifying record in column 10(a) and (b)
15. Reasons why this case deserves relaxation

Signature of Branch Manager

Rubber Stamp

BRANCH OFFICE.....

EMPLOYEES' STATE INSURANCE CORPORATION

From

To

The Manager, Branch Office,
.....
.....
.....
.....

The Medical Referee/
SMC/Administrative Medical Officer
Incharge
.....
.....

Under the treatment of

Dr.....
.....
.....

Insured person
Sex.....Age.....
Ins. No.....
Address.....

(State above full name, address and Ins. No.)

Date of last certificate received and form No. thereof.....

Cause of abstention from work in that certificate.....

It is requested that the above-named insured person who is medically certified as needing abstention from work since and the total period of 124 days in respect of whose disease is likely to expire on may be examined by you and the report as to whether it is a suitable case for extension of ESB upto 309 days be sent to this office.

Report of the specialist/hospital is enclosed.

Date.....

Signature of the Branch Manager
or other authorised officer

Encl:

REPORT OF THE MEDICAL REFEREE/SMC/ ADMINISTRATIVE MEDICAL OFFICER INCHARGE OR HIS NOMINEE.

The above named insured person has been examined and considering the report of the specialist, I recommend that ESB may be extended upto 309 days/may not be extended beyond 124 days.

Date.....

Signature of the Medical Referee / SMC
/ AMO incharge or his nominee

Combined Proforma for seeking sanction of Director General/Medical Commissioner (in case of para 1) and Regional Director (in case of amended para 5 of Corporation's Resolution dated 5.12.99)

Part 'A'

To be filled in by the Branch Manager and submitted to Medical Referee

1. Name of the office originating the proposal :
2. Name of insured person/insured woman :
3. Insurance No.(including regional code) :
4. Sex and Age :
 - (a) Date of birth :
 - (b) If (a) not available, year of birth :
5. Period, with dates, of present spell of long-term sickness involving payment of ESB :
6. Date of first certificate in the present spell :
7. Whether IP/IW is eligible for grant of ESB :
8. Is sanction to pay ESB required for :
 - (a) 'rare' disease? :
 - (b) beyond 309 days? :
9. In case of 8(a) above, indicate the following :
 - (a) Is sickness benefit continuing or exhausted? :
 - (b) Likely/actual date of its exhaustion :
10. In case of 8(b) above, indicate :
 - (a) date of commencement of ESB :
 - (b) likely/actual date of exhaustion of ESB for 309 days exclusive of days for which sickness benefit was availed :
11. (a) Whether IP/IW has resumed duty or is still continuing on leave ? :
 - (b) If duty has been resumed, date of resumption :
12. (a) Whether ESB was granted in the past for this disease or any other disease? :
 - (b) If so, give details :
13. Is request of IP/IW authorised beneficiary enclosed? :
14. Remarks, if any :

Date

Signature:

Designation:

Rubber Stamp:

Part 'B'

To be filled in by the SMC / Medical Referee

1. Full diagnosis of the case :
2. Present clinical condition of the IP/IW :
3. Whether IP/IW is expected to re-join normal economic activity on recovery? :
If so, when (approximately)? :
4. Summary of the case giving history, investigations, diagnosis, treatment given, progress etc. till date. (Please attach a separate sheet typed or legibly hand-written) :
5. (a) Is it a 'rare' disease (see para 1 of Corporation's Resolution – Annexure A/B – of ESB Law)? :
(b) If so, how? :
6. Reasons why this should be treated as a special case for grant of ESB beyond 309 days :
7. Opinion of Medical Referee/SMC :
8. List of copies of specialist opinion/investigation reports etc. attached (Give annexure with details) :
9. Period for which ESB on special grounds is sought (Give dates) :
10. Whether case is fit for reference to Medical Board? :
11. Referred to Medical Board :
12. Remarks, if any :

- Note:
- (i) Where sanction of Director General/Medical Commissioner is required for payment of ESB for 'rare' disease, case papers will be sent by Branch Manager to Medical Referee who will send them to SMC for his opinion/recommendation in Part 'D'. Part 'C' will be left blank and crossed.
 - (ii) Where sanction for ESB is required beyond 309 days, Medical Referee will submit papers to Medical Board and on examination by the Medical Board, Part 'C' will be filled in and the case papers will be seen by SMC for his/her opinion to be recorded in Part 'D' and forwarded to the Regional Director.

Date:

Signature of Medical Referee
(with rubber stamp)

Part 'D'

Recommendation of SMC / Senior MR (CMO scale)

1. What is the opinion of Medical Referee? :

2. What is the opinion of Medical Board? :

3. Do you agree with it? :

4. Are you satisfied that all the requisite papers are complete? :

5. Your Recommendations with justifications :

6. Remarks if any :

Signature:

Designation:

Rubber Stamp:

Date:

CHAPTER IX
MATERNITY BENEFIT LAW
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CHAPTER IX

MATERNITY BENEFIT LAW

Definition of maternity benefit

L.9.1. Maternity benefit consists of periodical payments in case of confinement or miscarriage or sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, to an insured woman being certified to be eligible for such payments by an authority specified in this behalf by the Regulations [Section 46(1)(b)].

L.9.2. Certain terms used in the foregoing para need to be clearly understood as follows :-

- (i) **Periodical Payments:** The payments to be made in respect of maternity benefit are periodical but the periods at which they are to be made are not fixed. Further, payments relating to this benefit cannot be commuted into a lump-sum.
- (ii) **“CONFINEMENT”** has been defined in sub-section (3) of Section 2 of the Act as “labour resulting in the issue of a living child, or labour after twenty-six weeks of pregnancy resulting in the issue of a child whether alive or dead”. In other words, if labour results in the issue of a still-born child before the expiry of 26 weeks of pregnancy, it will not be considered as confinement. On the other hand, if the still-born child is delivered after 26 weeks of pregnancy, it will be considered as confinement. Also, the issue of a living child has to be deemed confinement in any case.
- (iii) **“MISCARRIAGE”** has been defined in sub-Section (14-B) of Section 2 of the Act to mean “expulsion of the contents of a pregnant uterus at any period prior to or during the twenty-sixth week of pregnancy but does not include any miscarriage, the causing of which is punishable under the Indian Penal Code.”
- (iv) **Who is an ‘Insured Woman’?** The term “insured woman” has not been defined in the Act. However, sub-Section (14) of Section 2 defines an “insured person” as a person who is or was an employee in respect of whom contributions are or were payable under the Act and who is, by reason thereof, entitled to any of the benefits provided by this Act. The term “insured person” also includes an “insured woman”. By virtue of the definition of the term “insured person”, a woman can continue to be “insured woman” even after she has left insurable employment. She will thus be entitled to maternity benefit during a benefit period during which she may no longer be in insurable employment, provided she satisfies the contributory condition relevant to the said benefit period.
- (v) **Authority for certifying eligibility:** As per Regulation – 51 the Branch Office to which an insured woman is attached is the appropriate authority to certify eligibility and to admit claim for payment. The conditions that need to be satisfied for being eligible to benefit are discussed in the following paragraphs.

Contributory condition

L.9.3.1. Eligibility of insured woman to claim maternity benefit is determined by the provisions contained in sub-rule (1) of Rule 56 of the ESI (Central) Rules, 1950 which says that “an insured woman shall be qualified to claim maternity benefit for a confinement occurring or expected to occur in a benefit period, if the contributions in respect of her were payable for not less than seventy days in the immediately preceding two consecutive one or two contribution periods.

L.9.3.2. Where the IW is unable to satisfy the contributory condition as stated in the preceding paragraph, she will not be paid any maternity benefit by the Corporation. However, she can perhaps still be helped and guided to receive it from her employer under Section 5A of the Maternity Benefit Act, 1961, which states as under:-

5A. Every woman entitled to the payment of maternity benefit under this Act shall, notwithstanding the application of the Employees' State Insurance Act, 1948 (34 of 1948), to the factory or other establishment in which she is employed, continue to be so entitled until she becomes qualified to claim maternity benefit under Section 50. of that Act. (now Central Rule 56).

The said Act, under section 2(2) thereof, is normally not applicable to a factory/establishment to which the ESI Act applies, but an exception has been made in case of a woman falling under section 5A quoted above. Under section 5(2) of the said Act, a woman worker becomes entitled to payment of maternity benefit if she has worked in an establishment covered by that Act for a period of 70 days in the twelve months immediately preceding the date of her expected delivery. The period of 70 days is made up of days on which she actually worked, the days of lay off and paid holidays during the said period of twelve months.

L.9.3.3. A careful reading of sub-rule (1) of Rule 56 alongwith Regulation 4 will make the following points clear :-

- (i) To be eligible to maternity benefit, a confinement should either actually occur or should be expected to occur in a benefit period relevant to the insured woman. In other words, an insured woman who actually confines (or is expected to confine) on a date before the start of her first benefit period, is not entitled to claim maternity benefit even though part of the period of her maternity leave may fall within her first benefit period.
- (ii) Conversely, if the insured woman's date of actual confinement (or expected confinement) falls within her first benefit period, she will be entitled to maternity benefit even if a part of the period of her maternity leave may fall before the start of her first benefit period.
- (iii) As per paragraph L.9.3.1 above, an IW shall be eligible for maternity benefit if contributions in respect of her were payable for not less than 70 days in the immediately preceding two consecutive contribution periods. Even if she satisfied this contributory condition (either in one or the other) of the said two contribution periods, she shall be entitled for maternity benefit.

Duration of benefit for confinement

L.9.4.1. Sub-rule (2) of the said Central Rule 56 *ibid* says that an insured woman is entitled to receive maternity benefit for confinement for all the days on which she does not work for remuneration during a period of 12 weeks of which not more than 6 weeks shall precede the expected date of confinement. This sub-Rule provides as follows:

- (i) Maternity benefit for confinement is payable for a period of 12 weeks.
- (ii) It is payable for all the days on which the insured woman does not work for remuneration.
- (iii) In case insured woman claims maternity benefit before actual confinement, she is at liberty to do so but she must submit a certificate of expected confinement issued in accordance with regulations and the payment of maternity benefit will commence from a date –
 - (a) from which the benefit is claimed or
 - (b) from which work for remuneration is stopped or

- (c) 42 days before the expected date of confinement, whichever is the last (See Regulation 92).
- (iv) If an insured woman stops work for remuneration before confinement but submits her maternity benefit claim only after confinement, the period of 12 weeks shall commence on the date from which she has claimed the benefit and has stopped work for remuneration, irrespective of the fact whether or not she has submitted a certificate of expected confinement. In cases of this nature, the restriction of duration of 6 weeks prior to date of expected confinement will not be applicable as the same is relevant only when maternity benefit is claimed before confinement. In such a case the IW will get maternity benefit from the day she starts abstention if she claims it only after confinement i. e. after depositing her certificate specifying the date of confinement and she would be entitled to maternity benefit for 12 weeks from the date of abstention provided she satisfies the contributory condition with reference to the date of actual confinement.
- (v) If an insured woman does not abstain at all from work for remuneration before confinement and works for remuneration even on the date she confines, she will be entitled to maternity benefit for confinement for all the 12 weeks commencing from the date following the date of confinement provided insured woman does not work for wages during that period.

L.9.4.2. A week mentioned in the foregoing paragraphs is to be deemed as any period of 7 consecutive days. Thus “12 weeks” means a period of 12 consecutive weeks i. e., 84 consecutive days.

L.9.4.3. According to the provisions of sub-rule (2) *ibid*, an insured woman is entitled to maternity benefit for 12 consecutive weeks and on all the 84 days of these 12 weeks she must not work for remuneration. If she rejoins duty before the expiry of 12 weeks, maternity benefit must be stopped. However, she may again start abstaining from work in which case, maternity benefit can be resumed as a fresh claim and paid for all the days falling within the range of 12 weeks, no payment being made for the days on which she worked for remuneration. But the said days will be counted for the purpose of arriving at the total range of 84 days.

Duration and eligibility for miscarriage or medical termination of pregnancy

L.9.5.1. The opening words “An insured woman who is qualified to claim maternity benefit in accordance with sub-rule (1)” used in sub-rule (3) of Rule 56 *ibid* imply that for determining title to maternity benefit in case of miscarriage under the Sub-Rule, the benefit period in which the event of miscarriage takes place is relevant. If contributions in respect of the insured woman were payable for not less than 70 days in the two contribution periods immediately preceding the benefit period in which the miscarriage occurs, she will be entitled to maternity benefit for all days on which she does not work for remuneration during six weeks immediately following the date of miscarriage, at the maternity benefit rate. The period of 6 weeks for which maternity benefit is payable for miscarriage under the above provision may be in one spell or more, but it must be within the range of 6 weeks from the date immediately following the date of miscarriage.

L.9.5.2. In addition to cases of natural abortion, cases of voluntary or induced abortion coming within the scope of Medical Termination of Pregnancy Act, read with the definition of miscarriage under Section 2(14-B) of the Act automatically qualify the insured woman for maternity benefit for miscarriage as provided under Rule 56 (3) *ibid* subject to fulfilment of other conditions. Legal opinion obtained in this regard is reproduced below for guidance “Under Section 50 (3)¹, maternity benefit is permissible for miscarriage as defined in Section 2 (14-B), so long as it is not caused in the circumstances which constitute an offence under Indian Penal Code. It does not make any difference for the purpose of Section 50 read with Section 2 (14-B) whether the miscarriage is natural or caused voluntarily, so long as it is not an

¹. Now Central Rule 56 (3)

offence under Indian Penal Code. Voluntary miscarriage has ceased to be an offence to the extent permissible under Medical Termination of Pregnancy Act.”

Maternity benefit on death

L.9.6.1. Proviso to sub-rule (2) of Rule 56 *ibid* as amended with effect from 16.11.96 says that if an insured woman dies during her delivery or during the period immediately following her confinement for which she is entitled to maternity benefit, benefit will be payable for the whole of the period in either case provided she leaves behind the child. If, however, the child also dies during the said period immediately following the confinement, the benefit will be payable upto and including the date of death of the child. Benefit will be payable to the person nominated by the insured woman in the manner specified in the Regulations and if there is no such nominee, to her legal representative.

L.9.6.2. Maternity benefit would, however, be payable under this provision where the insured woman dies during her confinement or during the period immediately following her confinement for which she is entitled to maternity benefit, leaving behind in either case the child, and the period for which such benefit is payable will be limited to the maximum period of 12 weeks which is normally payable for confinement. This period of 12 weeks will be subject to the condition that the total duration of maternity benefit including the period, if any, preceding her confinement for which she received her maternity benefit and the period after confinement does not exceed, under any circumstances, a period of 12 weeks.

L.9.6.3. It will be clear from the foregoing discussions that in case of death of an insured woman – (leaving behind the child) within 12 weeks of her confinement, maternity benefit is payable upto and including the –

- (a) day of death of the child or
- (b) 84th day from the date of start of maternity benefit, whichever happens earlier.

Maternity benefit for sickness

L.9.7.1. Sub-rule (4) of Rule 56 says that an insured woman who is qualified to claim maternity benefit in accordance with sub-rule (1), is entitled to maternity benefit for an additional period not exceeding one month on account of her abstention from work as a result of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage or medical termination of pregnancy.

L.9.7.2. A month in the foregoing paragraph means a calendar month, e. g., 15.3.09 to 14.4.09 (31 days), or 11.2.08 to 10.3.08 (29 days), etc.

L.9.7.3. A reading of the above paragraph will establish that maternity benefit is admissible for sickness arising out of confinement or miscarriage or premature birth of child which contingencies occur on termination of pregnancy as well as for sickness arising out of pregnancy itself. An IW may suffer from sickness arising out of pregnancy as well as later after her pregnancy has terminated. In any case, the total duration of maternity benefit for sickness arising out of pregnancy or out of confinement, premature birth of child or miscarriage, cannot exceed one month. If such sickness continues beyond one month, only sickness benefit, if admissible, will be payable to the insured woman subject to deduction of the initial waiting period.

L.9.7.4. Sickness arising out of pregnancy may occur at a time when it may not be possible to determine the rate of maternity benefit. In such a case, sickness benefit may be paid to the insured woman. Later, when it is possible to determine the rate of maternity benefit on the basis of date of confinement/expected confinement or miscarriage, the difference between maternity benefit actually admissible and the sickness benefit already paid, may be paid to the insured woman.

L.9.7.5. Duration of one month for sickness arising out of confinement, premature birth of child or miscarriage would be counted on termination of the normal range of 84 days for confinement/premature

birth and 42 days for miscarriage. After determining this duration, the number of days for which maternity benefit was paid earlier for any sickness arising out of pregnancy will be deducted and the payment of maternity benefit for sickness arising out of confinement/miscarriage, will be admissible for the balance number of days. The total number of days comprising a 'month' in such a case shall be reckoned only as the number of days of the month in which the earlier spell of sickness (due to pregnancy) occurred.

L.9.7.6. "Threatened abortion" or "incomplete abortion" if supported by proper medical certificate requiring abstention from work on medical grounds, is a condition in which maternity benefit is payable for sickness arising out of pregnancy.

L.9.7.7. Diseases like anaemia, post-confinement weakness and allied symptoms occurring immediately after confinement as post-confinement anaemia are to be deemed as sickness arising out of confinement if supported by the requisite medical certificates. There is, however, need for caution and the diagnosis on medical certificate may be got confirmed from Medical referee.

L.9.7.8. An insured woman whose date of expected confinement and date of actual confinement both fall prior to commencement of her first benefit period but the spell of sickness arising out of confinement etc. starts only after the commencement of benefit period, will not be eligible for maternity benefit. In such a case, sickness benefit can be paid for the sickness arising out of confinement, etc., for the period falling in the benefit period if IW is found qualified in the relevant contribution period.

Daily rate of benefit

L.9.8. As per sub-rule (5) of Central Rule 56, "The daily rate of maternity benefit payable in respect of confinement occurring or expected to occur during any benefit period, shall be equal to twice the standard benefit rate corresponding to the average daily wages in respect of the insured woman during the corresponding contribution period or rupees twenty whichever is higher".

L.9.9. It is quite possible that an IW may qualify for maternity benefit with reference to contributions paid by her in two consecutive contribution periods immediately preceding the date of her confinement/expected confinement but the average daily wages may work out differently in each contribution period. In such a case, she will be entitled to higher of the benefit rates with reference to contributions paid by her in the two above-said contribution periods.

Criteria for determination of rate

L.9.10. The following criteria hold good for determination of eligibility as well as rate of maternity benefit for confinement : -

- (a) Where claim partly or wholly covers pre-confinement period and payments commence before actual confinement eligibility as well as the rate will be determined with reference to the benefit period in which the date of expected confinement falls.
- (b) Where the claim partly or wholly covers a pre-confinement period but payment of maternity benefit for this period has to be postponed till actual confinement, the eligibility as well as rate of maternity benefit is to be determined with reference to the benefit period in which confinement was expected to occur (provided certificate of expected confinement was submitted in accordance with Regulations) or with reference to the benefit period in which confinement actually occurs, whichever is more beneficial to the IW.
- (c) Where the claim covers only the period after confinement, the eligibility as well as rate of maternity benefit will be determined with reference to:
 - (i) the benefit period in which confinement actually occurs, if no certificate of expected confinement was submitted; or

- (ii) the benefit period in which the confinement occurs or the benefit period in which the confinement was expected to occur, whichever is more advantageous to the insured woman, provided that certificate of expected confinement was duly submitted strictly in the manner laid down in the Regulations and not otherwise.
- (d) where the claim covers a pre-confinement period and -
- (i) no certificate of expected confinement was issued, the eligibility and the rate of benefit admissible is to be determined with reference to the benefit period in which confinement actually occurs.
 - (ii) a certificate of expected confinement was issued before confinement but is submitted after confinement. In such a case, submission of certificate of expected confinement becomes infructuous. Hence, eligibility to maternity benefit as well as the rate of benefit admissible will be that determined with reference to the benefit period in which date of actual confinement falls.
- (e) Where claim is for sickness arising out of confinement, premature birth of child or miscarriage and where maternity benefit terminates on the last day of a benefit period or continues into the next benefit period and the sickness arising out of confinement, etc., commences thereafter, the rate of maternity benefit payable during the spell of sickness arising out of confinement or miscarriage will continue to be the same at which maternity benefit was paid, irrespective of the conditions obtaining in the subsequent benefit period.
- (f) Eligibility as well as rate of maternity benefit for miscarriage shall be determined with reference to the benefit period in which the date of miscarriage falls.

Claim before confinement

L.9.11.1. An insured woman who is pregnant may obtain a certificate of pregnancy in new form 17 and submit it alongwith a notice of pregnancy as per form below the said form 17. The notice of pregnancy, to be valid, must be submitted, by post or otherwise, to the Branch Office within 7 days of the date on which the certificate of pregnancy is obtained (Regulation 87). However, it is not compulsory for the insured woman to give any notice of the pregnancy but it is helpful for her to give notice because -

- (i) it helps to determine whether the birth of a dead child may be deemed as 'confinement' entitling her to maternity benefit for 12 weeks, or 'miscarriage' which entitles her to maternity benefit for just 6 weeks; and
- (ii) if she decides to move to her village for her confinement, it helps establish her *bona fides* for acceptance of birth certificate issued in her village.

L.9.11.2. As per Regulation 88, every insured woman claiming maternity benefit before confinement shall submit to her Branch Office by post or otherwise –

- (i) a certificate of expected confinement in the new Form 18 by IMO after deleting portions not relevant. To be valid, this certificate must be issued not earlier than 50 days before the expected date of confinement;
- (ii) a claim for maternity benefit in new form 19 stating therein the date on which she ceased/will cease to work for remuneration and
- (iii) within 30 days of the date on which her confinement takes place, a certificate of confinement in form 18 in which the IMO should have deleted the portions not relevant to the context.

L.9.11.3. However, the Director General has delegated full powers to Regional Directors, the Director, Sub-Regional Office, Pune and Joint Directors of SROs to relax Regulation 88(iii) regarding submission of certificate of confinement in new form 18.

Note 1. Payment of claim for pre-confinement period is not to await receipt of certificate of confinement.

Note 2. In cases where payment was started before confinement on the basis of the certificate of expected confinement, it will be continued for 12 consecutive weeks even if no child is born during this period. However, since a maternity benefit payment for confinement is based on the birth of a child, papers will remain incomplete until a certificate of confinement is received. Hence a careful watch should be kept over such cases when confinement is getting delayed.

Claim for miscarriage or after confinement

L.9.12.1. Under Regulation 89, every insured woman claiming maternity benefit for miscarriage shall, within 30 days of the date of the miscarriage, and every insured woman claiming maternity benefit after confinement, shall submit to the appropriate office by post or otherwise a claim for maternity benefit in form 19 together with a certificate of confinement or miscarriage in form 18 given in accordance with these regulations.

L.9.12.2. In other words, an insured woman claiming maternity benefit for miscarriage must submit to her Branch Office claim for maternity benefit in Form 19, accompanied by a certificate of miscarriage, within 30 days of the date of miscarriage. However, Regional Directors have been delegated power to relax the time limit of 30 days as provided in Regulation 89 up to a period of six months.

L.9.12.3. Regulation 89 quoted above also speaks of another important matter: claim for maternity benefit after confinement. For this type of claim, no time-limit has been laid down. In such cases, the time-limit for submission of claim for maternity benefit after confinement will be as stated in Explanation (a) below sub-section (1A) of Section 77 of the ESI Act. As for the issue of certificate, though there is no time limit in the regulations to obtain a certificate of confinement in cases where maternity benefit is claimed after confinement, it is in the interest of the insured woman to obtain certificate of confinement as early as possible after her confinement because delay in approaching the Insurance Medical Officer may result in disappearance of symptoms of recent child-birth (See also paragraph L.9.15)

Claim after death of IW

L.9.13. Regulation 89-A says that for the purposes of the proviso to sub-rule (2) of Rule 56 *ibid*, the person nominated by the deceased insured woman on form 1 or on such other form as may be specified by the Director General in this behalf and, if there is no such nominee, the legal representative, shall submit to the appropriate office by post or otherwise a claim for maternity benefit, as may be due, in new form 20 within 30 days of the death of the insured woman together with a death certificate in new form 21 given in accordance with these Regulations. In case of late submission, Regional Director has been delegated powers to relax the time limit upto a period of six months.

Claim for sickness arising out of pregnancy / confinement, etc.

L.9.14.1. Regulation 89-B says that (1) every insured woman claiming maternity benefit in case of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, shall submit to her Branch Office by post or otherwise a claim for benefit in the new form 9 (by deleting portions inappropriate to the circumstances of the case) copy at Annexure A- together with the medical certificate in new form 7 (in which portions inappropriate will be deleted by the IMO granting it), given in accordance with these regulations, and (2) the procedure for issue of these certificates will be the same as prescribed for these certificates in Regulations 55 to 61 and the time-limit for submission thereof shall be the same as prescribed in Regulation 64.

L.9.14.2. To enable correct classification and payment of maternity benefit, Insurance Medical Officer/Insurance Medical Practitioner issuing medical certificate for sickness in appropriate form, shall clearly indicate the sickness being due to pregnancy, confinement, premature birth of child or miscarriage as the case may be.

When claim becomes due

L.9.15. Under Regulation 45 (b), a claim for maternity benefit shall, for the purposes of Section 77 of the Act, become due -

- (i) in case of confinement, on –
 - (a) the date of issue of certificate of expected confinement; or
 - (b) a date 6 weeks preceding the date of expected confinement so certified, whichever is later, or
 - (c) if no certificate of expected confinement is issued, on the date of confinement.
- (ii) in case of miscarriage and in case of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, on date of issue of the medical certificate of such miscarriage or sickness, as the case may be.

The said section 77 says that any application before the Employees' Insurance Court should be filed within three years of the date on which 'cause of action' arose. 'Cause of action' for the purpose of filing the claim before the Court shall arise only if the claim for benefit has been made before the Corporation within a period of 12 months from the date it became due. As an illustration, an IW who was issued certificate of confinement on 1.1.2005 should submit a claim for the maternity benefit, complete in all respects, on or before 31.12.2005 and the application before the E. I. Court should be filed within 3 years of the date on which the claim for maternity benefit was filed with the Corporation. E. I. Court, however, may waive the period of 12 months for filing the claim before the Corporation on grounds which appear to the Court to be reasonable and it may admit an application even when the claim for it was filed late with the Corporation.

When claim becomes payable

L.9.16.1. The first payment of maternity benefit shall be made not later than 14 days after the claim therefor, together with the relevant medical or other certificates and any other documentary evidence which may be called for has been furnished complete in all particulars, to the Branch Office [Regulation 52 (1) (c)].

L.9.16.2. Second and subsequent payments of maternity benefit shall be made alongwith the first payment or within the calendar month following the month to the whole or part of which they relate, whichever is later [Regulation 52 (2)]. Where it is not paid within the aforesaid time limits, it shall be reported to the Regional Office and shall be paid as soon as possible [Regulation 52 (3)].

L.9.16.3. Maternity benefit cannot be paid in advance.

Notice of work

L.9.17. Every insured woman who has claimed maternity benefit (except in case of maternity benefit for sickness arising out of pregnancy, confinement, premature birth of child or miscarriage) has to give notice in new form 19 (after deleting portions not relevant) at the time she resumes work during the period of 12 weeks in case of confinement and 6 weeks in case of miscarriage (Regulation 91).

L.9.18. It may happen that although an insured woman has declared on her claim the date from which she ceased to work for remuneration, she might take up work for remuneration at any time during the period of 12 weeks for short intervals. Ordinarily, however, the notice will be given when the insured woman resumes work for remuneration before the termination of the 12 weeks' period as determined for her. However, as Form 19 does not specify the period for which she worked for remuneration, it will be necessary for her to submit a fresh claim form in case she ceases to work again during the currency of the 12 weeks' period as originally determined for her. The claim form will not be accompanied by a fresh certificate of expected or actual confinement. Benefit, which will have been stopped from the date of resumption of work earlier will, on receipt of a fresh claim, become payable again from the date of cessation of work upto the end of the 12 weeks' period originally determined for her. Similar will be the position with regard to 6 weeks following the date of the miscarriage.

Authority for issuing certificate

L.9.19.1. A certificate of pregnancy, expected confinement, confinement, miscarriage, sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, as well as of death of insured woman or of the child, under Regulation 87 to 89B, can be issued by an Insurance Medical Officer/Insurance Medical Practitioner to whom insured woman is allotted, or any other Insurance Medical Officer attached to the dispensary, hospital, clinic or other institution to which insured woman is or was allotted.

L.9.19.2. However, an Insurance Medical Officer/Insurance Medical Practitioner, other than the one aforementioned who is attending the insured woman for prenatal care, for confinement, for miscarriage or for sickness arising out of pregnancy, confinement, premature birth of child or miscarriage or who was attending the deceased insured woman or the child at the time of death of the insured woman or the child, may issue a certificate as aforesaid.

L.9.19.3. A registered midwife may also issue a certificate of pregnancy or expected confinement, confinement or miscarriage and such a certificate is acceptable to the Corporation on countersignature by an Insurance Medical Officer. Forms 17 and 18 have been designed to provide for signature by midwife and countersignature by the Medical Officer(Regulation 94).

L.9.19.4. But, a registered midwife cannot issue medical certificates in form 7 or 8 in respect of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage and such certificates have to be issued by the Insurance Medical Officer in accordance with Regulations 55 to 61. Further, these certificates must be submitted by the insured woman to her Branch Office within time-limits provided in Regulation 64 in the same manner as for certificate of ordinary sickness or temporary disablement.

L.9.20. A certificate of confinement on form 18 is issued by an Insurance Medical Officer/Insurance Medical Practitioner only if the IMO/IMP or the registered midwife attached to dispensary/clinic has attended the confinement, or the Insurance Medical Officer/Insurance Medical Practitioner, by examination of recent signs of delivery, is satisfied that confinement has taken place. In the latter case, the language of the certificate is suitably modified. If the delivery has taken place at the home of the insured woman, and it was not attended by IMO/IMP and she did not present herself in the dispensary/clinic for examination by IMO/IMP, the IMO/IMP will not issue a certificate of confinement in form 18.

L.9.21.1. The Corporation may accept any other evidence in lieu of a certificate of pregnancy, expected confinement, confinement, death during maternity, miscarriage or sickness arising out of pregnancy, confinement, premature birth of a child or miscarriage issued by an Insurance Medical Officer/Insurance Medical Practitioner if in its opinion the circumstances of any particular case so justify (Regulation 90).

L.9.21.2. Where the certificates are not issued by a registered midwife or Insurance Medical Officer/Insurance Medical Practitioner, the Regional Office may, in accordance with the instructions from

Headquarters, accept any other alternative evidence in lieu of certificate of pregnancy, expected confinement or confinement. If an insured woman cannot submit a medical evidence of her confinement either from an Insurance Medical Officer/Insurance Medical Practitioner or from any other medical practitioner, she may be asked to produce a certificate of birth from the Registrar of Births and Deaths, which may be accepted as alternative evidence under Regulation 90. Powers under Regulation 90 can be exercised only by the appropriate Regional Office.

L.9.22. If an insured woman who was under pre-natal treatment of her Insurance Medical Officer/Insurance Medical Practitioner and who has submitted a certificate of pregnancy from such Insurance Medical Officer/Insurance Medical Practitioner goes to her village for confinement, a certificate from police/patil, village headman or president of the gram panchayat certifying the fact of her confinement may be accepted as alternative evidence under Regulation 90 by the Regional Office provided that the insured woman is unable to obtain a certificate from the registrar of births & deaths

Benefits not to be combined

L.9.23. An insured woman will not be entitled to receive for the same period –

- (a) both sickness benefit and maternity benefit;
- (b) both maternity benefit and disablement benefit for temporary disablement.

Where an insured woman is entitled to more than one of the benefits mentioned above, she is entitled to choose which benefit she shall receive. (Section 65).

Disqualification for maternity benefit

L.9.24. An insured woman may be disqualified from receiving maternity benefit if she fails without good cause to attend for or to submit herself to medical examination when so required. She may, however, refuse to be examined by one other than a female doctor or a midwife. If an insured woman is disqualified as above, the disqualification is to be for such number of days as may be decided by the authority authorised by the Corporation, which is the appropriate Regional Office (Regulation 93).

Repayment of benefit improperly received

L.9.25. Where any insured woman has received maternity benefit when not lawfully entitled thereto, she is liable to repay to Corporation the amount of such payment. In case of her death, her legal representative is liable to re-pay the same from the assets of the deceased, if any, in his hands. The amount can be recovered as arrears of land revenue (Section 70 or Sections 45C to 45 I).

Reduction of existing benefits by employer

L.9.26. No employer by reason only of his liability for any contribution payable under the Act shall directly or indirectly reduce the wages of a woman employee or, except as provided by the Regulations, discontinue or reduce benefits payable to her under the conditions of her service which are similar to the benefits conferred by the ESI Act (Section 72). However, an employer may discontinue or reduce any maternity benefit granted to women employees to the extent to which such women employees may become entitled to maternity benefit under the ESI Act. Where an insured woman avails of any leave from the employer for maternity, the employer is entitled to deduct from the leave salary of the insured woman the amount of maternity benefit to which she may be entitled under the ESI Act for the corresponding period (Regulation 97). What has been said above relating to discontinuance or reduction of any benefit for maternity admissible for female employees pertains to only the benefit for maternity that is payable under the terms and conditions of service of such female employees. Position with regard to maternity benefit payable under provisions of Maternity Benefit Act is that when an insured woman is entitled to maternity benefit under the ESI Act she will not be entitled to receive any maternity benefit admissible under the provisions of any other enactment (Section 61). Please also see exception under

paragraph L.9.3.2 above which shows a way for an insured woman not found eligible to maternity benefit under the ESI Act.

Discharge etc. of an insured woman under certain conditions

L.9.27. No employer shall dismiss, discharge or reduce or otherwise punish a woman employee during the period she is in receipt of maternity benefit, nor shall he dismiss, discharge, reduce or otherwise punish a woman employee during the period she is absent from work as a result of illness duly certified to have arisen out of pregnancy or confinement rendering her unfit for work (Section 73 of the Act).

However, if the conditions of service of any insured woman so allow, an employer on due notice may discharge a woman employee who has been absent from work as a result of sickness arising out of pregnancy or confinement rendering her unfit for work, after she has been under such treatment or has been absent from work for a continuous period of 6 months or more (Regulation 98).

Payment of benefit to nominee of IW dying before confinement

L.9.28. Where an insured woman who is entitled to maternity benefit on the basis of a certificate of expected confinement dies before confinement, the payments made to her are in order. Any amount due till the date of her death can also be paid to her nominee or legal representative.

Confinement Expenses (earlier known as Medical Bonus)

L.9.29. In a move related to maternity benefit, but not strictly part of it, Rule 56A has been added to the ESI (Central) Rules, 1950. The said Rule amended as on 1.12.2008, reads as under :-

56A. Confinement Expenses – An insured woman and an insured person in respect of his wife shall be paid a sum of rupees two thousand five hundred per case as Confinement Expenses on account of confinement expenses w.e.f.. 01.12.08.

Provided that the confinement occurs at a place where necessary medical facilities under the Employees' State Insurance Scheme are not available. Provided also that confinement expenses are payable for two confinements only.

Thus, an IW as well as an IP whose wife confines at a place where medical facilities under ESI Scheme are not available, will be paid Rs. 2500/- as confinement expenses on production of proof of such confinement. The expenditure is to be deemed as part of medical benefit, to be shared between the Corporation and the State Government. The amount will be paid by the Branch Office. Please also refer to paras 12.C.1 and 12.C.2 of Chapter XII.

FORM . 9

CLAIM FOR SICKNESS/ T.D.B./ MATERNITY BENEFIT FOR SICKNESS

**EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 63 & 89-B)**

I, _____ Insurance No. _____ s/w/d of
_____ hereby claim Cash Benefit for period overleaf and state

- (i)* that because of sickness / temporarily disablement / sickness due to pregnancy / confinement / premature birth of child / miscarriage, I have not been at work since _____.
- (ii)* I no longer claim to be sick / temporarily disabled / sick due to pregnancy / confinement / premature birth of child / miscarriage from _____ and I shall / did not take up any work for remuneration before that date.
- (iii)* I have not been in receipt of any wages for the days of leave / holiday (s).
- (iv)* I was not on strike during the period of certified abstention on account of sickness / temporary disablement i.e. from _____ to _____ for which the benefit is claimed

I desire payment in * cash at Branch Office / by money order.

Signature or T.I. of claimant

Name in Block Letters _____
Address _____

Notes:

1. Any person who makes false statement or representation for the purpose of obtaining benefit whether for himself or for some other person renders shall be punishable with imprisonment up to 6 months or fine up to Rs. 2000/- or with both.
2. This form should be completed and submitted WITHOUT DELAY to the appropriate Branch Office.
3. A final certificate must be obtained before resuming work.

* Strike out if not applicable.

CHAPTER IX
MATERNITY BENEFIT PROCEDURE

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CHAPTER IX

MATERNITY BENEFIT PROCEDURE

Scrutiny of certificates

P.9.1. In respect of all certificates relating to maternity benefit, the following general points need to be checked: -

- a) Book No., Serial No., stamp of dispensary or of IMO/IMP on the certificate.
- b) The certificate has been issued from a book issued by the Branch Office/Regional Office for use by the IMO/IMP.
- c) All the existing instructions have been observed in writing the certificate, e. g., use of ball point pen and of double sided carbon paper, etc.
- d) The certificate bears the insured woman's signature/right thumb impression on top and also the code number of her employer.
- e) The signature of the Insurance Medical Officer/Insurance Medical Practitioner tallies with the specimen signatures kept in the Branch Office.
- f) The certificate is complete in every respect and wherever any modifications are required to be made in it, these have been duly made and all over writings/cuttings have been duly attested.
- g) The certificate is submitted within the time-limits stated in the relevant para and if it is delayed beyond the time-limits, relaxation of competent authority has been obtained.

Other checks to be applied to each kind of certificate have been mentioned in the relevant para.

Scrutiny of claims

P.9.2. In respect of all claims relating to maternity benefit, the following general points need to be checked/kept in mind:

- (a) The claim is on the correct form and is complete in all respects.
- (b) The signature of the insured woman tallies with the signature on her identity card. Further, the identity of the insured woman claiming benefit has been satisfactorily established.
- (c) The period for which benefit is claimed is the period for which the woman has actually abstained from work.
- (d) The insured woman does not appear to have joined insurable employment merely for the sake of claiming maternity benefit. This may apply to cases where insured woman claims maternity benefit for a confinement occurring or expected to occur during her first benefit period.
- (e) The identity of a pardah-nashin lady should be checked carefully with the help of a female employee of the Branch Office or another insured woman, so as to prevent impersonation particularly because a heavy amount of payment is involved.

Types of claims

P.9.3. A claim for maternity benefit may fall under five groups :-

- A. Where an insured woman (IW) ceases to work before confinement and submits a claim before confinement covering some pre-confinement period. This class of claims can fall into two sub-groups :-
 - (i) Where payment commences before confinement.
 - (ii) Where payment has to be postponed till confinement occurs.
- B. Where IW stops work after confinement or miscarriage and her claim relates to a period after confinement or miscarriage.
- C. Where IW stops work before confinement but submits a claim for benefit in respect of the pre-confinement period also only after confinement has occurred. This class of claims can also fall into two sub-groups :-
 - (i) Where IW does not submit a certificate of expected confinement, and
 - (ii) Where she submits a certificate of expected confinement but does not claim maternity benefit before confinement.
- D. Where IW dies during her confinement or during the period immediately following her confinement, leaving behind the child.
- E. Where IW needs abstention from work on account of sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, etc., for which maternity benefit is payable for an additional period not exceeding one month in accordance with sub-rule (4) of Central Rule 56.

A (i) Where payment commences before confinement

P.9.4. An insured woman claiming maternity benefit before confinement has to submit the following documents either personally or by post :-

1. A certificate of expected confinement on new form 18 (after deleting portions not relevant)
2. A claim on new Form 19 duly completed after scoring out portions not relevant.

In addition to the above, she has also to obtain and submit a certificate of confinement within 30 days of the date of her confinement in new form 18 wherein portions not relevant will be scored out.

P.9.5. An insured woman may also, at her discretion, submit a certificate of pregnancy (new Form 17) accompanied by a notice of pregnancy on the same form. If she does so, a notice of pregnancy will ordinarily be the first intimation the Branch Office receives in respect of IW intending to claim maternity benefit.

P.9.6. The claims clerk will check the certificate of pregnancy in the manner specified in para P. 9.1, diarise the same in the claims diary (ESIC-12) and keep it in the bundle of current medical certificates in serial order.

P.9.7.1. IW may submit the certificate of expected confinement (new form 18) either along with the certificate of pregnancy or at any time thereafter. In case she has not submitted a certificate of pregnancy

(accompanied by a notice of pregnancy), the certificate of expected confinement alone may be received in respect of her.

P.9.7.2. On receipt of the certificate of expected confinement, apart from the usual checks stated in para P.9.1, the following checks peculiar to this certificate will also be applied :-

- (i) The date of issue of the certificate of expected confinement is not more than 50 days before the expected date of confinement mentioned after the words “on or about” in the certificate.
- (ii) After the words “on or about”, a date has been duly filled in in the certificate.

P.9.7.3. A certificate issued earlier than 50 days before the expected date of confinement is invalid and the claims clerk will return it to the IW either personally or by post with a forwarding letter in form ESIC-162 duly signed by the Manager suitably advising this IW to submit a fresh certificate and a claim for cash benefit if she has stopped working for wages. A remark “Returned on” will be entered in the remarks column of the diary by the claims clerk who will also initial the entry.

P.9.7.4 On receipt of a valid certificate of expected confinement, it will also be seen that the claim form 19 printed on its back is also received complete in every respect. The fresh certificate of expected confinement and the claim will be diarised by the claim clerk in the claim diary (ESIC-12).

P.9.8. He will initiate action to get the ledger sheet prepared if it has not been opened so far.

P.9.9. The claims clerk will determine the benefit period in which date of expected confinement falls and process the claim for payment.

A (ii) Where payment is postponed till confinement.

P.9.10. If the insured woman is found ineligible for maternity benefit on the basis of certificate of expected confinement, the claims clerk will advise her accordingly. However, she may possibly become eligible in the benefit period in which she actually confines. In such a case, the insured woman may be advised to visit Branch Office again alongwith the certificate of actual confinement (new Form 18) certifying the birth of a child and her eligibility may be re-examined with reference to the date of her confinement.

B. Benefit Commencing after confinement or miscarriage

P.9.11.1. To establish her entitlement to maternity benefit when IW claims it for the period only after her confinement, she has only to submit a certificate of confinement (Form 18) alongwith her claim (form 19). Similarly, to establish her entitlement to maternity benefit for miscarriage which is payable only after miscarriage, IW has to submit a certificate of miscarriage alongwith her claim (Form 19). A certificate of miscarriage is issued on the same form 18 as for confinement with suitable modifications.

P.9.11.2. In case of miscarriage, Branch Office should ensure that the certificate contains :-

- (i) the date of miscarriage; and
- (ii) the week of pregnancy in which IW miscarried.

The information at (i) above will help determine her eligibility, rate of benefit and the date from which payable and the information at (ii) above will enable Branch Office to decide whether maternity benefit should be paid for six weeks for miscarriage or for confinement. Please refer to definition of ‘confinement’ and ‘miscarriage’ reproduced in para L.9.2.)

P.9.11.3. Maternity benefit will be payable for the date of miscarriage also provided she abstains from work on that day and is certified as needing medical treatment and abstention from work on medical grounds on that day. Payment for the day of miscarriage will be deemed as payment for sickness arising out of pregnancy and dealt with accordingly.

P.9.11.4. After the certificate of confinement or of miscarriage, as the case may be, is diarised, it will be subjected to scrutiny by applying the general checks prescribed in para P.9.1 and, in addition, the following :-

- (i) In case the claim is for maternity benefit for miscarriage, the certificate of miscarriage alongwith claim in new form 19 should have been submitted within 30 days of the date of miscarriage as provided in Regulation 89. When the certificate is not submitted within 30 days, the time limit will need to be relaxed by Regional Director if the certificate alongwith claim is submitted within 6 months of the date of miscarriage and by the Director General in case it is submitted thereafter.
- (ii) In case the claim is for maternity benefit for confinement (where IW claims it only after confinement) the Manager can pay maternity benefit if otherwise found admissible if the certificate of confinement alongwith claim in new form 19 is submitted within one year after the date of confinement. Any delay in submission of the claim for a period exceeding one year but within 6 years can be condoned by the Regional Director and, beyond this period, by the Addl. Commissioner/ Director (Benefits), Hqrs Office. Procedure for reference of time-barred claims to Headquarters Office will be found in Chapter XI *vide* para titled "Time Barred Claims" therein.

P.9.11.5. It should be noted that in every case of delay in submission of a certificate of confinement or of miscarriage beyond 4 weeks after the date of its issue, IW should be asked to give reasons for delay and these should be recorded. The Manager should consider the reasons for delay and record his recommendation and forward the case to the Regional Office for consideration.

C. Claim after confinement for some period before confinement

P.9.12.1. Claims of the above type can be divided into two sub-groups :-

- (i) Where IW does not submit a certificate of expected confinement; and
- (ii) where she submits a certificate of expected confinement but does not claim maternity benefit before confinement.

P.9.12.2. In respect of category (i) above, the IW would submit a certificate of confinement only which itself would be sufficient to establish her entitlement to maternity benefit for confinement for all the twelve weeks even if part of this period falls before the date of confinement.

P.9.12.3. In respect of category (ii) above, the IW will submit two valid documents viz., (a) certificate of expected confinement and (b) certificate of confinement. Eligibility and rate of maternity benefit will have to be calculated both with reference to the benefit period in which her expected date of confinement falls and also with reference to the benefit period in which her actual date of confinement falls and the IW would be entitled at higher of the two rates. If IW was eligible with reference to one benefit period and ineligible with reference to the other, she will still be entitled to claim maternity benefit at the rate at which she is eligible.

D. Where IW dies leaving behind child.

P.9.13.1. In case of claims falling under this category, the following documents will be necessary to establish a claim for maternity benefit :-

- (a) A claim in Form 24-A renumbered as form 20 w.e.f. 1.1.2005 (Annexure I) duly certified by an authority specified in the said form, together with –
- (b) a death certificate in new form 21.

P.9.13.2. By the time the above documents are received in the Branch Office, entitlement of the deceased IW for maternity benefit would have been decided on the basis of the certificate of expected confinement and/or of actual confinement. In that case, the claims clerk will need to check only the above referred documents. In case, however, the entitlement had not been decided by the time these documents are received, usual checks as referred to in para P.9.1 and other checks as specified in other paras relevant to the case will be applied.

P.9.13.3. Under Regulation 89-A, the above mentioned documents have to be submitted to the Branch Office within 30 days of the death of the insured woman. In case of delay in their submission, Manager may refer the case to Regional Director who can relax the time-limit for a period upto 6 months from the date of death. In case delay is longer, the matter will have to be referred to the Director General.

P.9.13.4. The claims clerk will also ascertain the name of nominee from the declaration form of the deceased IW.

P.9.13.5. Further action to make payment of maternity benefit to the nominee or, where there is no valid nomination, to the legal heir/representative, etc., will be taken in accordance with the relevant paragraph of Chapter III – General Claims Procedure.

P.9.13.6. The nominee or the legal heir/representative shall be paid benefit (including that which was admissible to the IW while alive but was not received by her) –

- (i) for the period upto and including the date of death of the child, or
- (ii) for a maximum period of 84 days (which should exclude the days for which she received maternity benefit for her sickness arising out of her pregnancy), whichever happens earlier.

E. Sickness arising out of pregnancy, confinement, miscarriage

P.9.14.1. To claim maternity benefit for an additional month for sickness arising out of pregnancy, confinement, premature birth of child or miscarriage, the insured woman would submit the following:–

- (i) a claim for benefit in new form 9 (after scoring out portions not relevant), together with –
- (ii) the appropriate medical certificate in new form 7 as first, intermediate or final certificate, as the case may be.

P.9.14.2. Whenever such a claim is received, the claims clerk will scrutinise the certificate in the same manner as applicable to certificates of sickness/temporary disablement. In addition, he will also check whether the IMO/IMP has clearly indicated the sickness being due to pregnancy, confinement, premature birth of child or miscarriage. These certificates should also be received within time-limits laid down in Regulation 64.

P.9.14.3. If a spell of sickness has arisen out of pregnancy, the claims clerk will need to ascertain the date of expected confinement so as to determine the eligibility and rate of benefit. In case that is not yet available, he will calculate the daily standard benefit rate and prepare claim for payment of sickness benefit and advise the insured woman to come again at the time of issue of a certificate of expected confinement or actual confinement when the rate of maternity benefit admissible to her for the earlier period would be available and she can be paid difference between maternity benefit due and sickness benefit being paid now, for a period not exceeding one month.

P.9.14.4. If the claim is for sickness arising out of confinement or miscarriage, the claims clerk will take the following steps :–

- (i) He will calculate the last day upto which normal maternity benefit is admissible.

- (ii) He will add one month to the last day. For instance, if the last day of normal maternity benefit was 13.4.09, then the insured woman can draw maternity benefit for sickness arising out of confinement etc. upto 13.5.09.
- (iii) He will deduct the days, if any, of maternity benefit drawn by the IW for sickness arising out of pregnancy. The period of one month for which maternity benefit is admissible for sickness arising out of pregnancy, confinement or miscarriage will be determined in accordance with para L.9.7.5.
- (iv) He will prepare the claim for maternity benefit for the rest of the days if duly certified by the Insurance Medical Officer.

Rate of benefit

P.9.15. On receipt of the certificate of (i) expected confinement, or (ii) actual confinement, or (iii) miscarriage in respect of an IW, her eligibility shall be determined and the rate of maternity benefit payable to her during the period she abstains from work on account of confinement or miscarriage or during her sickness arising out of her pregnancy, confinement or miscarriage shall be calculated by claims clerk in accordance with paras L.9.3.1 and L.9.8 to L.9.9.

P.9.16. It is possible that a second contribution period may have just ended before the date of expected/actual confinement and this contribution period will have to be considered for determination of IW's eligibility and daily rate of her maternity benefit. But the contributory record for the said second contribution period is neither due nor available in the Branch Office. In such a case, the Branch Office can call for the contributory record from the employer in ESIC-71 and if the IW is found entitled to a better rate, the B.M should cause wage verification made from the employer's record and, if satisfied, make payment at the higher rate as stated above. This would further need confirmation on receipt of RC for the said contribution period in the Branch Office, and the case would have to be noted in the ESIC-71 register.

If no benefit is admissible

P.9.17. If no benefit is admissible, the claims clerk will prepare a regret slip and he will also cancel the claim and the certificate with a rubber stamp. He will then write the words 'not admissible' in the column for 'remarks' in the ledger sheet of the IW concerned, and pass on the ledger to the checker with a request to see this case on a priority basis so that IW is not made to wait unnecessarily in the Branch Office.

Start of payment of maternity benefit

P.9.18.1 The claims clerk will determine the 12 weeks' period in case of confinement or 6 weeks' period in case of miscarriage and take steps to start payment of maternity benefit.

P.9.18.2. When payment of benefit has to be commenced before confinement on the basis of the certificate of expected confinement, it will have to be continued for all the 12 weeks even if child birth is delayed (refer also to note 2 below para L.9.11.3).

Notice of work

P.9.18.3. Where, during the period of 12 weeks in case of confinement and 6 weeks in case of miscarriage, an insured woman gives notice of work in new form 19 after scoring out portions not relevant, maternity benefit will be stopped with effect from the date of resumption of work. However, the insured woman may again submit a claim in fresh form 19 (which need not be accompanied by any certificate)

declaring that she stopped work from the date specified therein. In such an event, payment of maternity benefit to her will be resumed provided the period of abstention falls within the range of 12 weeks/6 weeks from the date on which maternity benefit was commenced on account of confinement/miscarriage. Such a claim will be diarised in the claims diary (ESIC-12) with a suitable remark and cross reference with the certificate of confinement/miscarriage received earlier.

First payment before confinement

P.9.19. Referring to paras P.9.4 to P.9.9, having determined the eligibility, the period and the rate of maternity benefit, claims clerk will await the insured woman's arrival in the Branch Office unless the insured woman has desired the payment by money order. In case the insured woman turns up in the Branch Office before her confinement, the claims clerk will prepare her claim for maternity benefit upto and including the date of her visit. He will also ask the insured woman how she would desire the subsequent payments of maternity benefit made to her. In case she wants them by money order, a written request may be obtained from her and recorded with the first payment whereafter payments will be remitted to her week after week without insisting upon a request for payment by money order. For this purpose, a reminder diary may be kept by him.

Ledger entries on payment

P.9.20.1. Having found the claim admissible for maternity benefit and having worked out the first payment, the claims clerk will complete entries in the ledger sheet as follows (in new series small-size ledger sheet):-

- (i) In column 4, the first date of the range for which maternity benefit is admissible and in column 5 the date upto which it will be admissible, should be entered. In case of death of insured woman, a fresh entry will be made in column 5 below the first entry which will be rounded.
- (ii) In column 6, the date of confinement/expected confinement/miscarriage will be entered with suitable remarks in abbreviation (e. g. cft, ecf, mcg for confinement, expected confinement and miscarriage respectively).
- (iii) In column 7 & 8, the period, i. e., date 'from' and the date 'to' for which the benefit is being paid on a given date, will be entered.
- (iv) In column 9, the number of days for which benefit is being paid, will be entered.
- (v) In column 14, the daily rate of benefit will be entered.
- (vi) In column 15, the amount of benefit due for the period in question will be entered.

P.9.20.2. The claims clerk will then fill up benefit payment docket and benefit payment slip and pass on the ledger to the checker for checking.

Other important matters

P.9.21. Certain important steps are required to be taken in the Branch Office before each maternity benefit claim gets paid. But, these matters are in common with other cash benefits for which a separate Chapter III – General Claims Procedure – is available and the same should be referred to in case of need. Some of the important matters which are relevant as part of Maternity Benefit Procedure but which will find a place in the Chapter III mentioned above, are as under :-

- Cent per cent checking of claims.

- Identification of claimant before payment.
- Attestation of thumb impression of claimant.
- Obtaining of proper acquittance by Cashier.

In order to avoid delay in payment of maternity benefit, the IW may be advised to -

- (a) give notice of pregnancy and submit certificate of expected confinement.;
- (b) submit her claim periodically;
- (c) submit the birth certificate from an ESI Dispensary, Hospital or Registrar of Births and Deaths or any other alternative evidence at the earliest; and
- (d) obtain letter from employer regarding abstention from the work.

Abstention enquiry

P.9.22 After the last payment has been made on a maternity benefit claim, the claims clerk before putting back the ledger, should initiate abstention enquiry from the employer to ascertain as to whether the insured woman did actually abstain from work for the period during which she has received maternity benefit. The claims clerk will prepare a letter for the employer in new form 10 (copy at Annexure II), delete portions not relevant and issue it under Manager's signature. The letter will be entered in the Branch Office Register of enquiries about abstention from work. When a reply is received from the employer, an entry will be made in the register of abstention enquiries by the claims clerk who will also examine whether the employer has confirmed the abstention of the insured woman. If the abstention is confirmed, the reply will be shown to the Manager and filed. Otherwise, the question of prosecution and/or recovery action against the insured woman shall be examined and further action taken in the same way as in similar cases of drawal of benefit by false declaration. Please also see para 11.35.1 in this connection which implies that maternity benefit is admissible to an insured woman who did not work for remuneration during the period for which she has claimed maternity benefit, irrespective whether she received any leave wages also for the days of her abstention or was on strike during the said period.

FORM 20

**CLAIM FOR MATERNITY BENEFIT AFTER THE DEATH OF AN
INSURED WOMAN LEAVING BEHIND THE CHILD**

**EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 89A)**

Claim arising from the death on of Ms.....
wife/daughter of.....having Insurance No. and last employed by
M/s.....

I , * being related to the above-named deceased insured woman as
her..... and being her nominee/ being her legal representative (applicable if the woman dies leaving no
nominee), hereby claim Maternity Benefit for the period from to

I also declare that –

**i) the deceased insured woman died on leaving behind the child
who is still alive, or

**ii) the deceased insured woman died on leaving behind the child
who also died on

The amount due may be paid to me by money order/ in cash at the Branch Office.

I further declare that the particulars, as given here-in-above, are true to the best of my knowledge and belief.

Dated.....

Signature / thumb impression
of the Claimant

Name in Block letters and _____

Address of claimant _____

ATTESTATION

***Certified that the declarations, as made here-in-above are true to the best of my knowledge and belief.

Signature
Name in block letters and rubber stamp or seal of Designation.....
the Attesting Authority

* Strike out this line if not applicable.

** Delete either (i) or (ii), as may not be applicable in the case.

*** This certificate is to be given by (i) an officer of the Revenue, Judicial or Magisterial Department; or (ii) a Municipal Commissioner; or (iii) a Workmen's Compensation Commissioner; or (iv) the head of gram-panchayat under the official seal of the panchayat; or M.L.A./M.P.; or (v) A Gazetted Officer of the Central/ State Govt./ Member of the Local Committee/Regional Board; or (vi) any other authority considered as appropriate by the Branch Manager concerned.

IMPORTANT:

1. This claim form duly filled up, is required to be submitted to the appropriate Branch Office together with a death certificate in Form 21 within 30 days of the death of the Insured Woman.

2. Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend up to six months or with a fine up to Rs.2,000/- or with both.

FORM-10

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

**EMPLOYEES' STATE INSURANCE CORPORATION
(Regulation 52A)**

From

The Manager,
_____ Branch Office,
ESI Corporation,

To

M/s _____

**Subject: Verification of abstention from work in respect of Sh./Shri./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 this 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**

CHAPTER X
FUNERAL EXPENSES - LAW & PROCEDURE
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CHAPTER X

FUNERAL EXPENSES - LAW & PROCEDURE

Provisions in the Act

10.1. Section 46 (1) (f) of the Act provides for payment to the eldest surviving member of the family of an insured person who has died, towards the expenditure on the funeral of the deceased insured person, or where the insured person did not have a family or was not living with his family at the time of his death, to the person who actually incurs the expenditure on the funeral of the deceased insured person (to be known as 'funeral expenses') : Provided that the amount of such payment shall not exceed such amount¹. as may be prescribed by the Central Government and the claim for such payment shall be made within three months of the death of the insured person or within such extended period as the Corporation or any officer or authority authorised by it in this behalf may allow.

10.2. According to definition given in clause (14) of Section 2 of the ESI Act, "insured person" means a person who is or was an employee in respect of whom contributions are or were payable under the Act and who is, by reason thereof, entitled to any of the benefits provided by the Act.

10.3 From the above it will be observed that a person who is no longer in insurable employment but is in receipt of periodical payments of permanent disablement benefit is an insured person and funeral expenses are payable in respect of death of such a person.

10.4.1 Similarly a person may be entitled to medical benefit alone on the date of his death. Funeral expenses will be payable for such a person also.

10.4.2. In terms of ESIC's circular No.6-1/91/71(M)-II, dated 03.01.78 to all State Governments an insured person whose title to medical benefit ceases while he is undergoing inpatient treatment in a hospital, or while receiving medical care and treatment at the time his exit intimation is received (in other words, his name is deleted from the 'Live List' of IPs entitled to medical care at the beginning of a new benefit period), continues to be entitled to medical care and treatment till the spell of sickness ends or in case of a long-term ailment as long as he requires active treatment. Funeral expenses were not payable in case such a person died while in receipt of medical benefit otherwise than under the normal rules. However, the ESIC at its meeting held on 14.12.1980 approved the grant of funeral expenses in respect of such persons also in case of deaths occurred on and after 14.12.1980.

10.4.3. It is to be noted that funeral expenses are not payable in respect of the death of a person who left employment on attaining the age of superannuation and became entitled to medical care under Central Rule 61.

¹. Amendment Act No. 44 of 1966 for the first time provided Rs. 100/- as 'funeral benefit'. The Corporation raised it under its powers in Sec. 99 of the Act to Rs. 500/- with effect from 1.1.1987.

The term 'funeral benefit' was replaced by the term 'funeral expenses' by the Amendment Act of 1989 with effect from 20.10.1989. *Vide* newly inserted Rule 59 in the ESI (Central) Rules, 1950, the Central Government raised 'funeral expenses' to Rs. 1000/- with effect from 1.2.1991. With effect from 16.11.1996, Rs. 1500/- was payable as 'funeral expenses' under Rule 59 *ibid* and Rs. 2500/- effective from 1.10.2000. After amendment in ESI Central Rule 59 an amount of funeral expenses of Rs.3000/- was payable w.e.f. 01.12.2007. After latest amendment in ESI Central Rule 59 an amount of Rs.5000/- is payable w.e.f. 01.09.2009 towards funeral expenses.

Death report

10.5. Under Regulation 95B, on the death of an insured person, a death report is required to be submitted immediately to the Branch Office of the deceased insured person by –

- (a) the employer, if the death occurs at the place of employment, or
- (b) the person entitled and intending to claim funeral expenses, if death occurs at any other place,
or
- (c) any other person present at the time of death, if he so desires.

Death certificate

10.6. As per Regulation 95C, the Insurance Medical Officer/Insurance Medical Practitioner attending the insured person at the time of death or the Insurance Medical Officer/Insurance Medical Practitioner who examines the body of the insured person after his death or the Medical Officer who attended the insured person in a hospital or other institution where such insured person died, shall issue, free of charge, a death certificate in form-13 (as at Annexure 'A') to the person entitled and intending to claim funeral expenses.

Other evidence in lieu of a certificate

10.7.1. Under Regulation 95D, in the absence of a death certificate in form 13 referred to above, any other alternative evidence of death can also be accepted in lieu of a death certificate if, in the opinion of the Corporation, the circumstances of any particular case so justify.

10.7.2. The Regional Director, Joint Director, Deputy Director and Assistant Director at the Regional Office level, and the Branch Manager at the Branch Office level, may accept the following documents as alternative evidence under Regulation 95-D for grant of funeral expenses.

- (i) Death certificate issued by cremation/burial ground.
- (ii) Death certificate issued by a Municipal Committee/Corporation/Government hospital.
- (iii) Certified copy of village death records etc.
- (iv) Death certificate issued by an Insurance Medical Officer/Insurance Medical Practitioner in form other than the form 13, e. g., in ESIC-MED-12, etc.
- (v) Death certificate issued by a Government or a recognised hospital, where the insured person was receiving indoor treatment.
- (vi) Such other evidence as may be acceptable to the appropriate Regional Office in the circumstances of a particular case and conveyed in writing by it to the Branch Office.

10.7.3. In case claimants need the original certificate for a *bona fide* purpose, e. g., for claiming provident fund dues etc., the original may be returned on receipt of written request and after keeping a photocopy to be attested by the Branch Manager. The Branch Manager must certify, while attesting, that he has seen the original death certificate.

Authority for certifying eligibility of claimant

10.8. Under Regulation 51, the authority to certify eligibility of a claimant in respect of funeral expenses is the appropriate Branch Office.

Submission of claim for funeral expenses

10.9. Regulation 95-E requires the claim for funeral expenses to be submitted by the claimant entitled to receive the same under the Act, to the appropriate Branch Office by post or otherwise in form 25-A renumbered as form 22 w.e.f. 1.1.05(Annexure 'B') supported by documents proving the death of the insured person and, in addition –

- (i) that the person claiming the funeral expenses is the eldest surviving member of the family of deceased insured person and incurred the expenditure necessary for the funeral of the deceased, or
- (ii) in case the claimant is other than the eldest surviving member of the family –
 - (a) that the deceased insured person did not have a family or that he was not living with his family at the time of his death, and
 - (b) that the claimant actually incurred the expenses claimed on the funeral of the insured person.

Provided that where the appropriate office is satisfied about the *bona fides* of the applicant or about the truth of the facts relating to any of the matters mentioned above, one or more of the documents may be dispensed with.

10.10.1. For the purpose of items (i) and (ii) of para 10.9 above, a declaration of the claimant duly countersigned by any of the under-mentioned authorities is considered to be sufficient proof and may be accepted : -

- (i) An officer of the revenue, judicial or magisterial department of the government;
- (ii) A Municipal Commissioner.
- (iii) A Workmen's Compensation Commissioner.
- (iv) The head of gram panchayat under the official seal of the panchayat or MLA/MP.
- (v) Gazetted Officer of Central /State Govt..
- (vi) A Member of the Local Committee /Regional Board.
- (vii) Any other authority considered as appropriate by BM concerned.

10.10.2. Any other evidence or declaration acceptable to the appropriate office in the circumstances of a particular case can also be accepted as proof for purpose of clauses (i) and (ii) of para 10.9 above.

10.11. Claim for funeral expenses is to be made within 3 months from the date of death of the insured person or within such extended period as may be allowed. The period of 3 months is to be reckoned from the day on which the insured person died.

When payable

10.12. As per Regulation 52(1)(b), payment of funeral expenses shall be made by the Branch Office within 15 days after the receipt of claim, complete in all respects.

Time barred claims

10.12.1. The Employees' State Insurance Corporation at its meeting held on 14th February, 1970 resolved that the Director General or such other officer of the Corporation as may be authorised by him and subject to such conditions as may be laid down by him from time to time, may, where circumstances of any case so justify, extend the period of three months for submission of claim for funeral expenses prescribed under Section 46 (1) (f) of the Employees' State Insurance Act upto two years.

10.12.2. The Director General has authorised Regional Director *vide* Hqrs. (Ins. II) Instruction No. 2 of 1986 dated 18.2.86 to admit claims for the payment of funeral expenses submitted within 2 years of the date of death of the insured person, if the reasons for the delay in submission of the claim so justify.

10.12.3. Since the Corporation has not authorised the Director General to admit a claim preferred more than 2 years after death of the insured person, such cases need not be referred to Hqrs. Office.

10.13. For the purpose of relaxation of provisions of section 46 (1) (f) the following may be considered as sufficient cause to justify condonation of delay : -

- (i) Ignorance of the provisions of the Act and Regulations.
- (ii) Late issue of death certificate.
- (iii) An insured person having died at outstation, or in his native place, being a case of permanent disablement benefit, etc.
- (iv) Any other circumstances which in the opinion of the Regional Director, justify the delay.

10.14. The delayed claim for funeral expenses which is required to be forwarded to the Regional Office for the sanction of the Regional Director should be referred in the proforma at Annexure 'C'

Payment procedure

10.15.1. Claims for funeral expenses are paid at the Branch Office. On receipt of a claim for funeral expenses, the same shall be diarised and scrutinised by the claims clerk to see if the requirements as provided in the foregoing paras have been complied with. It is, however, clarified that a claim supported by declaration and attestation would be sufficient and no vouchers/cash memos in support of expenditure claimed are necessary. It is also not necessary to enquire into the details of ceremonies on which expenditure has been incurred.

10.15.2. Where there is abnormal delay in submission of the claim, all possible care should be taken to scrutinise the claim papers thoroughly so as to ensure that the payment is promptly made to the right person.

10.16. If the claimant is a minor, the claim can be submitted by his/her guardian indicating the relationship to the claimant. In that case, the declaration in claim in form 22 can be suitably modified.

10.17. If the claim is otherwise in order, the claims clerk will prepare benefit payment docket and make an entry in the ledger sheet in red ink. This will generally be the last or closing entry in the document and may be entered on the sickness benefit column and further blank space on the page may be cancelled by a cross.

10.18. He will at the same time also cancel the certificate of death and the claim form (form 22) as at Annexure 'B' and make an entry about the death of the insured person in his declaration form (form 1).

10.19. The claim will then be passed on to the checker for checking and then to the Manager for pay order and finally to the Cashier for making payment. The cashier after payment will make necessary entry in the appropriate column of the schedule of benefits paid.

10.20. Funeral expenses is one of the statutory benefits. Therefore, its cost is booked under the head "B-Cash Benefits-Funeral Expenses".

10.21. Under Regulation 52 of the ESI (General) Regulations, 1950, payment of funeral expenses must be made by the Branch Office within a maximum period of 15 days after the claim thereof with relevant documentary evidence has been furnished to the Branch Office. It is absolutely essential to make payment of funeral expenses promptly and in actual practice the payment should be made immediately on the presentation of a proper claim.

10.22. Where the Branch Manager finds that the claim has not been submitted in time, he will obtain clarification in writing from the claimant about the reasons for delay in submitting the claim and may make a reference to the Regional Office immediately indicating the particulars required, in proforma at Annexure 'C'. In order to avoid inconvenience to the claimant he may, at the same time, be advised to submit a request for payment of funeral expenses through money order at an address to be indicated by him. It may, however, be clarified to him that the payment would be made only if the delay is condoned by competent authority.

10.23. According to the provisions of the Act, funeral expenses cannot be paid to more than one person. The Branch Manager may, therefore, obtain a declaration on Form 22, from the claimant to the effect that to the best of his knowledge and belief no other person except the claimant has incurred any expenditure on the funeral, before the payment is effected to the claimant.

FORM 13

EMPLOYEES STATE INSURANCE CORPORATION

DEPENDANTS' BENEFIT OR FUNERAL EXPENSES
(Regulations 79 and 95-C)

DEATH CERTIFICATE

Book No.....

Serial No.....

Stamp of the Dispensary

Name of the deceased insured person.....

s/w/d of.....Insurance No.

--	--

I certify that in my opinion the above-named deceased insured person died on theday of.....(month).....(year) as a result of an injury/ due to *.....I ** had been attending him/her for providing medical benefit before his/her death and I attended him/her for the last time on the.....day of.....

Date.....

Signature.....

Insurance Medical Officer/I.M.P

Rubber stamp or name
in block letters

Any other remarks by the Medical Officer

* Please indicate the name of the disease.

** The language may be suitably amended if the Insurance Medical Officer had not attended the deceased person before his/her death.

FORM 22

EMPLOYEES STATE INSURANCE CORPORATION
(Regulation 95-E)
FUNERAL EXPENSES CLAIM FORM

Claim arising out of death onof..... s/w/d of
.....aged.....years, having Insurance No.

--	--

employed as by

M/s.....Code No.....

I..... s/w/d of.....aged
.....years declare :-

* i) that I am the eldest surviving member of the family of the deceased insured person, whose particulars are furnished here-in-above, and that I actually incurred an expenditure of Rs. _____
(Rupees _____ only) necessary for the funeral of the said deceased person.

or

* ii) that the deceased insured person, whose particulars are furnished here-in-above did not have a family/was not living with his family at the time of his/her death and that I actually incurred an expenditure of Rs. _____
(Rupees _____ only) on the funeral of the deceased insured person.

iii) To the best of my knowledge and belief no other person except me has incurred any expenditure on the funeral.

Accordingly, I do hereby claim funeral expenses for the amount of Rs. _____ (Rupees _____ only)

Date.....

Name in Block
Letters _____

Signature or thumb impression
of the claimant

ATTESTATION

** Certified that the declarations, as made here-in-above, are true to the best of my knowledge and belief.

Name in block letters and rubber stamp or seal of the attesting authority
--

Signature.....

Designation.....

Date.....

* Delete either (i) or(ii), which may not be applicable in the case.

** This certificate is to be given by (i) an officer of the Revenue, Judicial or Magisterial Department, or (ii) a Municipal Commissioner; or (iii) a Workmen's Compensation Commissioner; or(iv) the Head of the gram Panchayat under the official seal of the Panchayat, or M.L.A./M.P.; or (v) A Gazetted Officer of the Central/State Govt., (vi) a member of the Local Committee/Regional Board or (vii) any other authority considered as appropriate by the Branch Manager concerned.

Important : Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend up to six months or with a fine up to Rs.2,000/-, or with both.

Note : In case of a minor, the guardian should sign the claim form on behalf of the minor, and then add the following below his /her signature:-

(Name of the minor)
Through _____
(Name of the guardian)
his/her _____
(Relationship with the Minor)

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CHAPTER XI

MISCELLANEOUS MATTERS CONNECTED WITH CLAIMS & PAYMENTS

A. INCAPACITY REFERENCES TO MEDICAL REFEREE

Provisions in the Regulations

11.1. Under Regulation 105 of ESI (General) Regulations, 1950, “Where any question arises as to correctness of any certificate by virtue of which an insured person claims, or is entitled to, any benefit under the Act, he shall, on being so required in writing or otherwise by the appropriate office submit himself, with a view to obtaining a further certificate, to medical examination by such medical authority as the Corporation may appoint in this behalf. If the further certificate specifies the date on which the insured person is or will be fit to resume work, any certificate which is or has been issued by the Insurance Medical Officer for the same spell of incapacity shall, to the extent to which it relates to any period after and including the said date on the further certificate, be deemed not to have been issued in accordance with these Regulations and such further certificate shall, notwithstanding anything contained in these Regulations, be deemed to be a final certificate”.

11.2. This Regulation further states that notwithstanding anything contained in those Regulations, such further certificate in so far as it relates to sickness or temporary disablement, may be issued at such intervals and in respect of such periods as may be specified by such medical authority.

11.3. Such a medical authority is designated as Medical Referee who is usually a full-time officer of the Corporation. In small centres, however, a Medical Officer of a comparatively senior rank of the State Government is generally designated by the Corporation as a part-time Medical Referee with the approval of the State Government concerned. These Medical Referees entertain and dispose of incapacity references, consultation references and miscellaneous references from Regional Office/Branch Office for medical opinion.

Incapacity reference – what and when?

11.4. A reference made by the Branch Office to ascertain Medical Referee’s opinion on whether incapacity of an insured person is continuing is termed as an incapacity reference. For this, a letter is addressed by the Branch Manager to the Medical Referee in form RM-1. At the same time an entry is made in the register of incapacity references of the Branch Office as well as in the remarks column of ledger sheet. A copy of the proforma of the register (form ESIC-59) is at Annexure I.

11.5. The Medical Referee on its receipt, writes to the insured person as well as to the treating IMO/IMP on form RM-2 and RM-3 respectively. In RM-2, Medical Referee asks the insured person that if he has not yet obtained final certificate, he should contact his IMO/IMP. The Medical Referee also directs him to appear for examination by him on the date and time and at the place to be mentioned. In RM-3 addressed to the treating IMO/IMP, the Medical Referee asks him to provide a history of the case and the treatment given to the insured person so far. In case a final certificate has already been issued, there is no action on the part of the IMO/IMP and he has to return it with suitable remarks.

11.6. An incapacity reference is also sometimes initiated by the treating IMO/IMP whenever he has a doubt whether insured person needs abstention on medical grounds. Form RM 1 (a) is used for the purpose.

11.7. The above procedure, viz., initiation of incapacity references either by Branch Office or by the IMO/IMP holds good at places where a full time Medical Referee is posted and where work relating to fixation of date and time of examination and of sending intimations to the insured persons and to the Insurance Medical Officers is done in the office of the Medical Referee. Certain important variations of this procedure have also been laid down in different circumstances as explained below :-

- (i) At any time when BM observes a sudden rise in the incidence of sickness/temporary disablement, he may decide to issue a large number of incapacity references even on the first certificate on priority basis with a view to curbing certification. In that case, the BM will ascertain the date, time and place of examination by the Medical Referee on telephone or otherwise and will issue forms RM-2 on Medical Referee's behalf to the insured persons. As a further variation, he may take every insured person's signature/thumb impression in the register of incapacity references and treat the same as intimation to the insured person. He may also hand over form RM-3 to the insured person to get it filled in by the treating IMO/IMP and to present it before the Medical Referee at the time of his examination.
- (ii) At a smaller centre where there is no full-time Medical Referee and a part-time Medical Referee has not been appointed, a full-time Medical Referee visits the centre at regular intervals. The following procedure is followed at such a centre for initiation and disposal of incapacity references :-
 - (a) The Branch Manager prepares a consolidated list of incapacity references on form RM-1(M), copy at Annexure II. This list is updated constantly.
 - (b) On receipt of Medical Referee's tour programme, the Branch Manager reviews the list and issues RM-2 and RM-3 on Medical Referee's behalf to those persons for whom an incapacity reference is due and for whom the final certificate has not so far been received.
 - (c) An up-to-date list in form RM-1(M) alongwith forms RM-3 received from the IMOs/IMPs and prepared forms RM-4,5 and 6 are handed over to Medical Referee at the time of his visit.
- (iii) At a centre which is not frequently visited by the full-time Medical Referee, a senior Medical Officer of the State Government or even the seniormost Insurance Medical Officer or Branch incharge of the centre is appointed as part-time Medical Referee. At such a centre, a consolidated list of incapacity references is prepared in form RM-1(P) - specimen at Annexure III, dispensary/clinic-wise and sent to part-time Medical Referee. A copy of this list is also sent to concerned dispensary/clinic and the IMO/IMP enters his clinical notes and other remarks in the relevant columns against the name of each insured person and sends the same to Medical Referee before the date of examination. Forms RM-2 are issued by the Branch Office to the insured persons. Usually the part-time Medical Referee has fixed dates of examination for each Branch Office or dispensary as may be convenient to him and to the insured persons. A clerk of the office of part-time Medical Referee is appointed on payment of prescribed allowance for assisting him in filling up various forms and returns and also assisting insured persons in claiming conveyance charges, etc.
- (iv) In certain centres a retired senior Medical Officer is appointed as part-time Medical Referee on a fixed remuneration and he generally functions in a Branch Office/Regional Office premises and clerical assistance is provided to him by the Branch Office/Regional Office staff.

Guidelines for making incapacity reference

11.8. The following guidelines should be followed in regard to intervals at which incapacity references would be initiated: -

- (i) Incapacity reference should be initiated after 14 days from the date of commencement of spell of sickness or temporary disablement, i. e., at the time when the second intermediate

certificate for the spell in each case is received. Where no such certificate is received within eight days of issue of first intermediate certificate, an incapacity reference may be initiated even without the second intermediate certificate. If a final certificate is received within eight days of issue of first intermediate certificate, no incapacity reference need be made.

- (ii) If the spell of sickness or temporary disablement continues beyond 14 days from the date of issue of first certificate, incapacity reference is to be initiated at the interval of 2 weeks till the final certificate is issued.
- (iii) In cases where the Medical referee visits only once in a month subsequent incapacity reference may be issued at an interval of one month only as the insured person is not expected to be examined more than once in a month.

More frequent references

11.9. In addition to incapacity references made at regular intervals, incapacity references should be made at shorter intervals as may be considered appropriate in the following cases :-

- (a) Where the insured person has had frequent spells of sickness, specially of short duration.
- (b) Where the diagnosis is vague. For vague or doubtful diagnosis, the incapacity reference be made immediately on receipt of the first certificate.
- (c) Where a person had claimed benefit for more than two spells in a benefit period.
- (d) Where the disease is one in which malingering is possible.
- (e) In case of excessive certification resulting from a lock out, closure, etc., priority incapacity references should be initiated even on receipt of first certificate.
- (f) A priority incapacity reference is also to be made in respect of an insured woman who produces medical certificates certifying her as suffering from anaemia, or post-confinement weakness or allied symptoms etc., following confinement and claims maternity benefit for sickness arising out of pregnancy/confinement/miscarriage etc.

Less frequent references

11.10. In the following specific cases, a departure from the frequency laid down is indicated:

- (i) No incapacity reference is necessary if the insured person exhausts his sickness/extended sickness benefit and he is no longer entitled to cash benefit, or if an IW exhausts her maternity benefit for sickness arising out of pregnancy/confinement.
- (ii) In case of amputation of part of a limb a subsequent reference may be initiated at longer intervals of 3 to 4 weeks.
- (iii) In case of insured persons suffering from the following long-term diseases for which ESB is payable, incapacity reference may be initiated after every three months:

1. Tuberculosis
2. Malignant diseases (cancer)

3. Paraplegia
4. Hemiplegia
5. Non-union or delayed union of fracture
6. Leprosy
7. Hemiparesis of more than eight weeks' duration
8. Cardiac valvular diseases with failure/complication
9. Chronic obstructive lung disease (COPD) with congestive heart failure (Cor pulmonale)
10. Post-traumatic surgical amputation of lower extremity
11. Compound fracture with chronic osteomyelitis
12. Chronic renal failure

In respect of other long-term diseases for which ESB is payable incapacity reference will be made at intervals of 28 days each.

- (iv) Initial or subsequent incapacity reference may be made at intervals longer than 4 weeks in cases where a special intermediate certificate is issued by the Medical Referee.
- (v) So long as insured person is actually undergoing in-patient treatment in a hospital, incapacity reference need not be made. However, incapacity reference should be made immediately after the discharge of the insured person from the hospital, provided that incapacity is still continuing and the patient is not immobile.
- (vi) In cases where the medical certificate shows that the insured person has left the station with the permission of the IMO/IMP, no incapacity reference is otherwise due. However, a reference should be initiated if and when the insured person submits a further intermediate or special intermediate certificate.

Other references

11.11. In case of an employment injury sustained more than 7 days earlier than the date of issue of first certificate, a reference should be made to the Medical Referee requesting him specifically to advise whether the present incapacity is, in his opinion, connected with the employment injury sustained earlier. The particulars of such accident should be furnished to him at the time of reference. In case the gap between the date of injury and the date of issue of first certificate is upto 7 days, Branch Manager may himself accept the certificate provided that the description of the injury given in the certificate tallies with that given in the accident report and Branch Manager is otherwise quite satisfied about the genuineness of the disability arising as a result of employment injury.

11.12. Where there is a relapse of incapacity due to an employment injury, incapacity reference should immediately be made by the Branch Office on receipt of the first certificate in the subsequent spell of incapacity. But, in cases where the first certificate in the subsequent spell is submitted late or where the diagnosis on such first certificate does not seem to be apparently connected with the employment injury, the Branch Office will not be in a position to make a reference. However, as soon as subsequent certificate indicating a relapse of employment injury is received, or when the subsequent spell is later claimed to be connected with the employment injury, an incapacity reference should be made forthwith.

Action by Medical Referee

11.13.1. An insured person referred for Medical Referee's opinion will be examined by the Medical Referee only if a final certificate has not been issued to him. The Medical Referee will intimate his opinion both to the Branch Manager and to the IMO/IMP in form RM-4 and RM-5 respectively. The opinion given by the Medical Referee will be that the insured person –

- (a) “does not now need abstention from work” OR (b) “still needs abstention from work”

If Medical Referee expresses opinion at (a), he will also issue RM-10 to the insured person to enable him to resume duty.

11.13.2. The reference made in respect of insured person to whom the final certificate is issued before the date of examination by Medical Referee will also be disposed of by him by issue of RM-4 and RM-5 to the Branch Manager and IMO/IMP.

11.14. It sometimes happens that the insured person for whom an incapacity reference has been issued and a final certificate has not yet been issued may fail to attend for examination before Medical Referee. In that case, the Medical Referee will dispose of the reference by writing to Branch Office Manager and the Insurance Medical Officer in forms RM-4 and RM-5 that insured person failed to attend.

Action in Branch Office

11.15. The following procedure will be followed by the Branch Office for payment/suspension of benefit to insured person in respect of whom an incapacity reference is being/has been initiated either by the Branch Office or by the Insurance Medical Officer:

- (i) Benefit should be withheld from the date fixed by the Medical Referee for examination of the insured person to the date on which the report of the Medical Referee is received. The date of examination should be recorded in the relevant column of the ledger sheet of the insured person and benefit should be paid only upto the date immediately preceding the date fixed for examination.
- (ii) In case the date of examination is not readily ascertainable, benefit should be withheld in respect of period covered by certificates subsequent to the date of issue of incapacity reference.
- (iii) Where the intimation in RM-4 received from the Medical Referee says that the insured person still needs abstention, the benefit already withheld will be paid and further benefit will also be paid to the insured person on the basis of IMO/IMP's certificate, if he is otherwise eligible.
- (iv) Where the insured person has been declared fit by the Medical Referee, the benefit will be paid upto and including the day of examination, unless it is specifically mentioned by the Medical Referee that the insured person could resume duty on the same day or on any other day if so specified.
- (v) Where the insured person has failed to attend, no benefit is payable from the day of examination onwards. In cases where the insured person fails to attend on the fixed date and, on examination by the Medical Referee on a later date, he is declared fit, he should be paid upto the day preceding the date fixed for the first examination by the Medical Referee.
- (vi) If a final certificate is issued to an insured person before the date fixed for examination by Medical Referee or before the date on which the insured person receives the

intimation for appearance before Medical Referee (on form RM-2), he is not to appear before the Medical Referee and the benefit should be regulated in accordance with the final certificate issued to him.

11.16. If an insured person is called to appear before the Medical Referee on a day on which as per final certificate he was due to resume work but could not do so owing to his appearance before the Medical Referee, no benefit should be paid to the insured person for that day.

11.17. In some cases of failure, an insured person may have failed to report due to some valid reasons, e.g., intimation on form RM-2 or RM-2(a) did not reach him in time or was returned to the Medical Referee due to incomplete address. If a representation is made by the insured person to the Branch Office and the insured person produces evidence to the satisfaction of the Manager that form RM-2 was not received by him in time, the date on which he actually received the intimation may be treated as the date fixed for examination by Medical Referee and the Manager may direct the insured person to the Medical Referee for examination or clarification. The Medical Referee will examine the insured person immediately and communicate his opinion to the Branch Office and the IMO/IMP on form RM-4 and RM-5 respectively. Particulars in the printed form RM-4 and RM-5 which are not applicable will be scored out by the Medical Referee and the relevant replies to the queries asked for will be indicated in the blank space on RM-4/5. A reference to the previous form RM-4/5 will also be indicated as "in continuation of RM-4/5".

11.18. Where, however, an insured person reports for examination after a period of 14 days from the date when he was due for examination, a fresh reference on form RM-1 will be initiated as usual by the Branch Office. It may also happen that an insured person who has failed to attend the Medical Referee on the date fixed for examination approaches the Medical Referee instead of the Branch Manager within 14 days of the date originally fixed for examination. The Medical Referee need not ask the insured person to get a letter from the Branch Office before examination, and may examine him immediately. The Medical Referee is not expected to go into the question whether failure to attend on due date was for genuine reasons or not. After examination, the Medical Referee would communicate his opinion to the Branch Office and the IMO/IMP on forms RM-4 and RM-5 respectively, after giving a reference thereon to RM-4 and RM-5 issued previously at the time when the insured person failed to attend.

Cases where insured persons fail to appear before Medical Referee for examination.

11.19. Where an insured person had earlier failed to attend for Medical Referee's examination on a first incapacity reference made by the Branch Office and if on the second medical examination conducted within 40 days of the date fixed for the first examination, the Medical Referee finds that the incapacity is continuing, benefit already suspended should be restored by the Branch Office from the date from which it was suspended. If, however, the insured person is found fit for work on such second examination the decision to suspend benefit shall not be reversed by the Branch Office. Regional Director may, however, in cases where insured person is found fit for work on such examination or on examination conducted within 40 days of the date fixed for examination by Medical Referee, restore the benefit if he is satisfied about the reasons for failure of the insured person to appear before Medical Referee on due date.

11.20. If an insured person suffering from any of the diseases for which ESB is granted fails to appear before the Medical Referee on due date for the medical examination and on subsequent examination conducted within three months from the date fixed for the original medical examination by Medical Referee, the insured person is found needing abstention from work, the BM may himself restore the benefit to the insured person.

11.21. At a centre outside the headquarters of the Medical Referee where an insured person fails to appear before Medical Referee and a fitness certificate is issued by the IMO/IMP within 14 days of the date of first examination but prior to second examination by the Medical Referee, the BM may, if he is satisfied about the reasons for failure to appear before Medical Referee, restore the benefit.

11.22. If, on the second medical examination conducted 40 days after the date fixed for the first examination, the Medical Referee finds that the incapacity is continuing, decision to suspend the benefit will not be reversed by the Branch Office but payment of benefit shall be resumed with effect from the date of second medical examination.

11.23. The Regional Director may restore benefit in all other cases which fall outside the powers of Branch Manager irrespective of the time lag involved, in consultation with the Medical Referee if he is posted in the Regional Office.

11.24. Where an insured person who was taking inpatient treatment in a hospital and whose benefit has been suspended because he failed to appear before Medical Referee on the due date fixed for examination subsequently produces evidence of his having been admitted to the hospital by way of hospital discharge certificate, his benefit may be restored by BM without any reference to Regional Director/Medical Referee.

11.25. Where the insured person fails to appear before the Medical Referee on the date fixed for medical examination for the reason that he had left the station with the prior permission of the IMO/IMP, the BM may condone the absence of the insured person before Medical Referee and restore the benefit without reference to the Regional Director. The BM may also restore benefit where an insured person is declared fit before second examination by the Medical Referee is arranged, provided that the BM is satisfied that the insured person failed to appear before Medical Referee due to non-receipt of intimation from the Medical Referee or produces proof of the late receipt of intimation.

11.26. An insured person called for examination on a certain date may have been issued final certificate before that date. However, he may again be on certified incapacity after a short interval and may actually be on certified incapacity on the date fixed for examination in respect of the subsequent spell of incapacity. In such cases the reference will not be restricted to the spell in which RM-1 is issued but will as well cover the new spell, if any, which is current on the date of examination by the Medical Referee and the decision of the Medical Referee will apply to the second spell.

B. CONVEYANCE/LOSS OF WAGES

Standing Committee's Resolutions

11.27.1. The Standing committee, in its Resolution dated 16-3-53, approved the payment of conveyance allowance and/or compensation for loss of wages to IPs called to appear before the Medical Board.

11.27.2. The Standing Committee in its Resolution dated 25.11.53 authorised the payment of conveyance charges to an insured person who is asked by the Branch Office to appear before a Medical Referee for examination under Regulation 105 on the same conditions and at rates prescribed for insured persons appearing before a Medical Board. The Standing Committee also approved that the Medical Referee would exercise the power similar to that delegated to the Medical Board for authorising the payment of conveyance charges.

When admissible

11.27.3. As per the decisions and resolutions of the Standing Committee/Corporation, conveyance charges and/or compensation for loss of wages are admissible to persons appearing before a Medical Referee in the following circumstances :-

Cases in which admissible	Nature and extent of compensation available
1. Insured persons referred by the Branch Office to MR for second medical opinion under Regulation 105 and for confirmation of disease for ESB.	Conveyance charges only.
2. Insured persons requiring artificial limbs referred to MR for report in connection with suitability for fixing an artificial limb.	Conveyance charges and/or compensation for loss of wages.
3. Referred by Branch Office/Regional Office to MR for opinion whether his/her case is fit for reference to the Medical Board.	Conveyance charges and/or compensation for loss of wages.
4. Referred by Branch Office for advice of Medical Referee on advance payment of permanent disablement benefit.	Conveyance charges and/or compensation for loss of wages.
5. An incapacity reference made to the Medical Referee for his opinion whether the insured person's present incapacity is connected with (a) the employment injury sustained more than 7 days before the date of issue of first certificate, or, (b) is a relapse of spell of temporary disablement.	Conveyance charges only.

When not admissible

11.27.4. Payment of conveyance charges and/or compensation for loss of wages is not admissible in the following cases:

- (1) An insured person referred by Insurance Medical Officer for a second medical opinion of Medical Referee. This also includes cases where insured person himself appears before Medical Referee appealing for a medical certificate refused by the Insurance Medical Officer.
- (2) Cases referred by Regional Office/Branch Office for determining normal expectation of life.
- (3) Cases of alternative evidence of incapacity referred by Regional Office/Branch Office for opinion whether abstention recommended in the certificate submitted by the insured person is reasonable.
- (4) Sometimes the Medical Referee may be consulted for opinion whether assessment of loss of earning capacity awarded by the Medical Board is reasonable and the Medical Referee calls the insured person for examination. No conveyance charges and/or compensation for loss of wages is admissible in such cases also.

Expenses – a distinct entry in a/cs

11.28. In order to avoid any abuse of this concession and to provide a proper check over the expenditure, it was decided that the expenditure to be incurred in connection with conveyance charges/compensation for loss of wages payable to insured persons shall be booked under a separate head of account and shown as a separate item in the budget estimates.

Conveyance charges

11.29.1. Director General has authorised the Medical Referees who have been declared as 'Head of Office', to exercise the power of sanctioning compensation for loss of wages and/or payment of conveyance charges to the insured persons called to appear before them for purposes of Regulation 105 of the Employees' State Insurance (General) Regulations, 1950, subject to the conditions and rates mentioned below:

- (a) If the insured person is fit to attend a State Insurance Dispensary/Clinic, no conveyance charges shall be paid to him for attending at an examination centre unless the distance between the centre and the place of his residence exceeds three kilometres.
- (b) Subject to the above provision, an insured person will be paid conveyance charges incurred by him for journeys from the place of his residence to the examination centre and back; provided that such charges shall not exceed normal bus or rail charges between the two places by the shortest route or Rs. 2/- per kilometre where there is no tram/bus, or railway service between the two places.
- (c) Where the Medical Referee/examining doctor is satisfied that an insured person is not fit to travel by train, bus or other ordinary means of conveyance or needs an attendant to accompany him, the insured person may be paid the actual conveyance charges incurred by him, at a rate not exceeding *Rs. 4/- per kilometre instead of the charges referred to in the foregoing paragraph.
- (d) Where the claim is for a distance not exceeding 3 Km., conveyance charges may be paid if Medical Referee certifies that the insured person was not fit to attend the dispensary.
- (e) For an insured person who travels by rail, second class rail fare will be admissible unless it is certified by Medical Referee that the insured person cannot sit up for any length of time and has to lie down. First class fare will be admissible to such a person.

Loss of wages

11.29.2. Compensation for loss of wages to insured persons referred to at serial no. 2, 3 and 4 of para 11.27.3 will be regulated by the following instructions:-

- (i) Where an insured person has lost wages on account of his attendance for examination by the Medical Referee, he shall be paid by way of compensation a day's wages or half-a-day's wages for each day or days on which he lost wages depending on whether more or less than half-a-day's wages were lost.
 - (ii) Subject to other conditions stated herein, the rate of compensation payable for loss of wages will be the least of the following:-
 - (a) Actual wages lost for half day or full day, as the case may be;
- OR
- (b) W. e. f. 1-4-1996 an amount double the standard benefit rate admissible to the IP in the benefit period at the time of examination by MR for full day's wages lost or half day's wages lost, as the case may be.

OR

- (c) Average daily wages payable. Average daily wages will be equal to monthly/fortnightly/weekly/daily wages, divided by 26/13/6/1 respectively as the case may be, for monthly/ fortnightly/weekly/daily rated employees.
- (iii) If an insured person is not in employment, or takes leave with wages from his employer, no compensation for loss of wages will be payable. In that case, it is not necessary for the insured person to get the endorsement in part-B of form ESIC-142 (specimen at Annexure IV) from his employer and the claim may be admitted for payment of conveyance charges without insisting upon employer's endorsement on this form.
- (iv) If an insured person is referred to the Medical Referee for opinion whether he is a fit case for reference to the Medical Board and the Medical Referee refers him to a specialist/hospital for opinion/examination, the insured person may have to incur conveyance charges and/or loss of wages for visiting the specialist/hospital. Conveyance charges and/or compensation for loss of wages would also be payable to the insured person for such visits.

When MR cannot reach examination centre

11.29.3 It sometimes happens that the Medical Referee is unable to turn up on the day fixed for examination of certain insured persons. Conveyance charges and/or compensation for loss of wages are payable for the date of the examination to those insured persons who turn up at the place of examination. Since each form ESIC-142 has to be certified by the Medical Referee, who is not available, before payment of conveyance charges and/or compensation for loss of wages can be made to these insured persons, non-payment may result in hardship to them. The following officers have been authorised to certify the claims in the absence of the Medical Referee to enable payment of conveyance charges and/or compensation for loss of wages without delay:-

- (a) Manager of the Branch Office concerned, if the Medical Referee's examination centre is the Branch Office.
- (b) An officer authorised by the Regional Director where the examination centre is the Regional Office.
- (c) Insurance Medical Officer incharge where the examination centre is the ESI Dispensary.

Only ordinary conveyance charges are payable in the above cases in view of the fact that only Medical Referee can certify whether an insured person is unfit to travel by ordinary mode of conveyance.

Payment procedure for appearance before Medical Referee

11.30.1. The procedure for payment of conveyance charges and/or compensation for loss of wages will be as follows:-

- (a) The conveyance charges and/or compensation for loss of wages shall not be paid in advance, except conveyance charges for the return journey after examination by Medical Referee.
- (b) Every insured person claiming conveyance charges and/or compensation for loss of wages shall submit the claim to Medical Referee concerned in form ESIC-142 (copy at Annexure IV)

- (c) If any insured person claims that he is not fit to travel by train or bus or other ordinary means of conveyance or he has to travel by train in a lying position or that he needs an attendant to accompany him, his claim must be supported by a certificate to that effect from the Medical Referee.
- (d) Necessary stock of forms ESIC-142 should be kept in the Medical Referee's office or at the office where references are initiated, for supply to those insured persons who wish to claim conveyance charges and/or compensation for loss of wages. Necessary clerical assistance for filling up the form should also be provided to the insured persons.
- (e) Conveyance charges and/or compensation for loss of wages shall ordinarily be made at the Branch Office out of Account Number-2 of the Branch Office and booked under the detailed head "C-other benefits—Payments to insured persons on account of conveyance charges and/or compensation for loss of wages".
- (f) Entries regarding payment of conveyance charges and/or compensation for loss of wages would be recorded in a register maintained for the purpose at the Branch Office in the following proforma:-

**REGISTER OF CLAIMS PAID FOR CONVEYANCE
CHARGES AND/OR COMPENSATION FOR LOSS OF WAGES TO
INSURED PERSONS APPEARING BEFORE MEDICAL REFEREE**

Sl. No.	Name of the IP with Ins. No.	Full residential Address	Date of examination	Distance travelled		
				From	To	Km
1	2	3	4	5(a)	5(b)	5(c)
Mode of conveyance: Train/bus/rail/ special conveyance	Amount claimed		Amount paid		Initials of the BM/gazetted officer with date	Remarks
	Conveyance charges	Compensation for loss of wages	Conveyance charges	Compensation for loss of wages		
6	7	8	9	10	11	12

Payment procedure for appearance before Medical Board

11.30.2. The procedure for payment of conveyance charges and/or compensation for loss of wages described in the foregoing paragraphs is specific in respect of IPs appearing before Medical Referee. The same procedure is also applicable *mutatis-mutandis* in respect of IPs appearing before the Medical Board for assessment of loss of earning capacity and has to be followed by the Regional Office/Branch Office. Certain special features of the procedure in respect of IPs appearing before Medical Board have been stated in relevant Chapter V – PDB Procedure – and may be noted therefrom for compliance in addition to, or in modification of, the foregoing procedure, as the case may be.

Payment procedure for appearance before M. A. T.

11.30.3. The Standing Committee resolved in its Resolution dated 2-6-1975 that the Corporation may pay conveyance allowance and/or compensation for loss of wages to insured persons called to appear before a Medical Appeal Tribunal, in cases filed by the Corporation or by the insured persons at the same scale and subject to the same conditions as are applicable in cases where the insured person appears before a Medical Board.

C. ENQUIRIES REGARDING ABSTENTION FROM WORK

No wages for paid holiday/leave or strike

11.31.1. Section 63 of the Act says that save as may be provided in the regulations, no person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he works or remains on leave or on a holiday in respect of which he receives wages or on any day on which he remains on strike.

Exceptions : Regulation 99A

11.31.2. Regulation 99A is reproduced below:

99A. Sickness or temporary disablement benefit during strike.–

No person shall be entitled to sickness benefit or disablement benefit for temporary disablement on any day on which he remains on strike except in the following circumstances –

- (i) if a person is receiving medical treatment and attendance as an indoor patient in any Employees' State Insurance Hospital or a hospital recognised by Employees' State Insurance Corporation for such treatment; or
- (ii) if a person is entitled to receive extended sickness benefit for any of the diseases for which such benefit is admissible; or
- (iii) if a person is entitled to receive sickness benefit or disablement benefit for temporary disablement immediately preceding the date of commencement of notice of the strike given by the employees' union(s) to the management of the factory/establishment.
- (iv) if an insured person/insured woman has undergone operation on account of vasectomy/tubectomy, he/she shall be entitled to enhanced sickness benefit on any day on which he/she remains on leave during the period of strike or remains on leave, or on holiday for which he/she receives wages.

11.31.3. It will be clear from the reading of the above-quoted Section and Regulation that maternity benefit as well as enhanced sickness benefit have been totally excluded from the provisions of Section 63, and extended sickness benefit is partially excluded. For maternity benefit the only condition the IW must satisfy is that as provided in Central Rule 56(2), she must not work for wages for all the days for which she claims maternity benefit. The same is the position in respect of enhanced sickness benefit.

11.31.4. Table given below describes the nature of cash benefit admissible or otherwise during paid leave/paid holiday or during the period of strike:

Nature of cash benefit	Whether cash benefit admissible during		
	Paid leave	Paid holidays	Strike period
Sickness benefit } Temporary disablement benefit }	No	No	No., except (a) when admitted in the ESI Hospital; (b) if already in receipt of SB/TDB before notice of strike.
Extended sickness benefit	No	No	Yes
Maternity benefit	Yes	Yes	Yes
Enhanced sickness benefit	Yes	Yes	Yes

Abstention enquiry

11.32. Under Regulation 52A, every employer is obliged to furnish a reply to any abstention enquiry made by the Branch Office in respect of various benefits paid to insured persons/insured women.

Abstention enquiry procedure

11.33. The following comprehensive instructions should be followed in the matter of initiation of abstention enquiries:-

- (a) At the time of passing claims for payment the BM should personally mark the cases in which abstention enquiries may be made, ensuring that such enquiries cover in due course employees of all the factories and in all wage groups. To these may be added cases where the Manager may suspect a wrong declaration by an insured person. Enquiries must also be made invariably when an insured person exhausts 91 days' benefit for the first time. Such enquiries may initially be in not less than 5% of the number of payments each day. For maternity benefit cases, please refer to Chapter IX – Maternity Benefit Procedure.
- (b) Further, with a view to check the misuse of benefits at a centre where the incidence of sickness benefit and/or temporary disablement benefit is more than the All-India average, the Branch Manager should review the incidence of sickness benefit and temporary disablement benefit at the end of every month by calculating the same in accordance with the following formula:-

$$\text{Incidence of cash benefit} = \frac{\text{Total No. of benefit days in the month}}{\text{Approved No. of employees attached to the Branch Office for the year}} \times 12$$

He should compare the result with the figure of All-India average incidence available at the time of review both in case of sickness benefit and temporary disablement benefit and if the incidence at his Branch Office exceeds the All-India average, he should raise the abstention verification rate to 10% of the total number of payments made during the month under the

respective benefit. In addition, he should also make abstention verification of every case where the insured person has drawn benefit for 45 days or more in two consecutive benefit periods. This should be followed strictly.

- (c) Normally, the enquiry may be made for the complete present spell for which payment is made. However, further enquiries may be made in respect of all spells of incapacity for which payment was/is made in the preceding and the succeeding six months in respect of those insured persons who are found to have given wrong declaration. Abstention verification should also be made for every spell when the insured person exhausts 91 days' benefit. This will not include those cases where the insured person was found to have worked on the first day or last day of the period covered by the claim.
- (d) Abstention enquiries should invariably be issued in all cases where payment of benefit is made in advance of last date of sickness/temporary disablement certified on a first-cum-final or final certificate.
- (e) As stated in (a) above, abstention enquiries should be initiated in such a way as to cover employees of all the factories and establishments attached to the Branch Office so that if any untoward trend is discovered in case of employees of a particular factory/establishment, the percentage of enquiries should be increased from 5% to 10% or more if found necessary and a vigorous drive for prosecution, (besides recovery), of those insured persons who are found to have obtained cash benefit by false declaration should be launched. The Manager may conduct the investigation in such a factory/establishment and take remedial measures including educating its workers and making them fully aware of consequences of wrong declaration including the stringent provisions now made in Section 84 in the shape of higher penalties and disentitlement to cash benefits by the Corporation, of those IPs who are convicted for false declaration (refer to paras L.3.39 & L.3.40 of General Claims Law (Chapter. III).
- (f) When payment of benefit is made on the basis of hospital admission and discharge certificate, abstention enquiry should be conducted invariably.

11.34. An abstention inquiry is to be made in form 10, which may be completed by the claims clerk, in accordance with the instructions of the Branch Manager. As already stated, an intelligent selection of cases for abstention verification should be done personally by the Manager and it should not be left to the Head Clerk or any other subordinate official. The system of selection should be such that no one in the Branch Office should be able to predict the likely references. This work of issue could be done after payment hours but references can be signed by the Head Clerk or by the UDC Incharge/Cashier on Manager's behalf. At the same time, necessary entries may be made in the Branch Office register in form ESIC-60 (Specimen at Annexure V) and completed form 10 may be despatched to the employers concerned. Date of issue should be invariably put on the form 10. On receipt of the replies from the employers, further entries may be made in the register.

11.35.1. In the reply to form 10 received from employer in respect of SB/ESB/TDB, if employer confirms the abstention and also confirms that no wages were paid for any holidays or for leave and that the IP was not on strike, no further action is called for and the reply may be filled after making entries in the register. Similarly, if in the reply received back from the employer for maternity benefit and enhanced sickness benefit, he confirms abstention from work but shows wages paid for any holidays/leave to IP/IW during the period of abstention, no action lies on the part of the Branch Office and reply may be filed. The replies should be filed date-wise in a separate file with cross reference to entries in ESIC-60 register.

11.35.2. If the reply to form 10 received from the employer shows that leave wages for any of the days or holiday wages were paid to the IP, or he had worked for wages for any of the days for which he had received SB/ESB/TDB or he remained on strike during the whole or part of the period for which he had received SB/TDB, suitable entry should be made in the register in form ESIC-60 and necessary action may be taken for prosecution and/or recovery of amount of benefit wrongfully received.

11.35.3. As regards cases of maternity benefit and enhanced sickness benefit, if the reply to abstention enquiry reveals that IP/IW worked for any day for which he/she has received maternity benefit/enhanced sickness benefit recovery action should be initiated straightaway. Form ESIC-96 (Annexure VI) should be sent to the IW/IP through the employer and the employer be requested to hand over the same to the IW/IP concerned and to forward to the Branch Office a receipt in token of his having received the letter. In case the employee has left the particular employer in the mean-time, and the letter is received back undelivered, the same may be sent again to the IW/IP at his permanent address or any other address where the IW/IP may be reported to be residing or working.

11.36. Replies from the employers to form 10 issued to them should be watched strictly and a reminder should be issued after 15 days of the initiation of this form. If no replies are forthcoming from an employer or he is persistently avoiding to furnish replies, legal action should be recommended against such an employer whenever considered necessary. For such cases, the Branch Manager should furnish full particulars to the Regional Office, indicating the steps taken by him for obtaining the replies from the employer and also his recommendation for legal action against the employer. Regional Office should follow the prescribed procedure for prosecution of such cases.

11.37. Form 10 should be sent by ordinary post. However, where legal action is contemplated against an employer, a proper reminder be issued by registered A. D. post, enclosing therewith a list of the cases of abstention verification giving name, insurance number and period of abstention by each IP/IW to which the employer has failed to reply, asking him to comply within 15 days failing which prosecution action will be recommended to Regional Office.

Monthly summary

11.38. A summary of abstention enquiries will be drawn up every month in the following form and posted in the ESIC-60 register:-

1. No. of benefit payments made during the month.
2. (a) No. of forms 10 issued during the month for SB/TDB/ESB cases.
(b) No. of forms 10 issued during the month for Maternity Benefit/enhanced SB cases.
(c) Total
3. Percentage of 2 to 1
4. (a) No. of form 10 of first category pending at the end of previous month.
(b) No. of forms of second category pending at the end of previous month
(c) Total
5. Total of columns 2 & 4
6. No. of replies received during the month including those for previous month:
(a) Forms 10 of first category: (b) Forms 10 of second category: (c) Total
7. (a) No. of forms 10 of first category pending at the end of month
(b) No. of forms 10 of second category pending at the end of month
(c) Total

8. No. of cases of wrong declaration detected during the month.
9. No. of cases where action against the employer for non-submission of form 10 (both categories) recommended.

At the end of each quarter ending on 31st March, 30 June, 30th Sept., and 31st December every year, the following columns may also be added:

10. (a) No. of forms 10 of first category issued in the quarter

(b) No. of forms of second category issued in the quarter

(c) Total

11. No. of replies received for the quarter

(a) Form 10 of first category:

(b) Form 10 of second category:

(c) Total

12. Percentage of 11 to 10

No laxity in abstention enquiry

11.39. Inspecting Officers during the course of their visit to the Branch Office should see whether the instructions in this regard are being followed by the Branch Manager or not. In case any laxity is found on the part of Manager, suitable action may be taken against him.

Erroneous reply to abstention enquiry

11.40. Sometimes, on the basis of information received from the employer on abstention verification by the Branch Office, the recovery of excess payment of cash benefit is made from an insured person. But subsequently, the employer gives a contrary statement regarding the abstention of the insured person from work and part or whole of the amount has to be refunded to the insured person. The following instructions may be followed when such a case arises :-

- (a) The employer should be asked to certify the facts of abstention now reported by him in writing.
- (b) The first case that may arise may be verified by means of spot investigation by an official not below the rank of upper division clerk and, if there are more such cases from the same employer, at least one out of every five cases should be investigated at higher level.
- (c) The information received from the employer may be treated as a claim which should be accepted and details of the original payment and the recovery made earlier should be indicated on this claim.
- (d) A benefit payment docket may be prepared, the benefit may be paid to the IP and entry made in the schedule of benefits paid.
- (e) The amount refunded should be debited to the benefit to which it relates.

D. RECOVERY OF EXCESS PAYMENTS

Causes of excess payments

11.41. An excess payment may result from many factors, specially the following:-

- (i) False declaration by insured person which came to notice on receipt of reply to abstention enquiry.
- (ii) Wrong calculation of rate of benefit.
- (iii) Wrong calculation of amount of benefit.
- (iv) Erroneous counting of days of any benefit, specially sickness benefit.
- (v) An insured person failed to attend for examination by Medical Referee but payment was continued beyond the date of examination.

Action for recovery

11.42. As soon as excess payment is noticed, it must be entered in the register of over payments in form ESIC-138 (specimen at Annexure VII) to enable recovery to be pursued effectively. Names alongwith designations of persons responsible for overpayment have to be entered in column 13 of this register. An entry in red ink should also be made in the ledger-sheet of the insured person after the last payment entry and action should be initiated to effect recovery from the insured person and should be pursued vigorously. In all cases where payment involved is in excess of Rs. 75/- in a case, steps to effect recovery as arrears of land revenue under Section 70 of the ESI Act should invariably be taken.

Waiver of excess payment

11.43. There might be cases in which for one reason or the other, recoveries could not be effected for a considerable period. Such cases should be reported to Regional Office from time to time for waiver of recovery. The Director General has empowered the Dy. Regional Director/Asstt. Regional Director and the Regional Director to waive recovery of excess payment to the insured person upto Rs. 5/- and Rs. 1000/- respectively in an individual case, in consultation with the Deputy/Assistant Director (finance) at the Regional Office. Cases involving excess payment of over Rs. 1000/- are to be referred to the Headquarters Office. The following time-schedule has been laid down for this purpose:-

- i) The Branch Office should send the quarterly statement to the Regional Office within 10 days from the expiry of the quarter.
- ii) The Regional Office/Sub Regional Office should, in turn, submit the quarterly return on the prescribed format by the 20th of the following month of each quarter to Headquarters Office.

The quarterly statement for the quarter ending March, June, September and December will be submitted by the Branch Office to Regional Office/Sub Regional Office in form MISLO-11 by 10th of April, July, October and January respectively. The Regional Office/Sub Regional Office should, in turn, submit the quarterly return on the prescribed format (Annexure VII A) by the 20th of the following month of each quarter to Headquarters Office. Full facts of each case leading to overpayment and action taken for recovery with reasons why recovery is not possible should be explained fully in the statements. This should include action taken by way of recovery under Section 70 and/or prosecution under Section 84, specially where amount involved is substantial. Only those cases should be included in the quarterly statement for waiver of recovery where the recovery proceedings have failed.

Watch through ledger sheet

11.44. Once recovery has been waived in a case, it may be treated as closed and entries in ESIC-138 register vacated and no further action pursued for recovery. This is necessary to avoid keeping the

entries in ESIC-138 register open in respect of long outstanding cases. However, as the particulars of overpayments would have already been entered in the ledger sheet, the recovery can be effected any time an insured person against whom recovery is outstanding calls at the Branch Office for receiving payment of a cash benefit. Where recovery is made by adjustment out of any further benefit admissible to the insured person, his written consent should be obtained before making the adjustment.

11.45. The recovery, if effected in the same financial year in which the overpayment was made, will be taken as a reduction of the expenditure originally charged for. In case the recovery is effected in a year following the year in which the original payment was made, the amount of recovery is to be credited as revenue under the head "VII-Miscellaneous-Miscellaneous".

11.46. In cases of over-payment involving Re. 1/- or less no notice for recovery need be issued to the insured person concerned. Instead, the following procedure may be adopted in such cases:—

- (a) Such overpayment should be indicated in the register of overpayment in form ESIC-138.
- (b) A note regarding the overpayment should be made on the ledger sheet of the insured person concerned and the amount should be recovered when a subsequent claim arises as described hereinabove.
- (c) Such cases should be referred to the Regional Director for waiver of recovery, in case the amount could not be recovered.

Action where officials responsible for overpayments

11.47. As already stated above, if recovery of overpayment is not found possible, the case is to be referred to the Regional Office at the appropriate time for waiver. Overpayments recommended for waiver should be entered in the Defaulters' Note Book as per proforma given below, to be maintained at the Regional Office. Since the Corporation has suffered financial loss, responsibility for overpayment is to be fixed before waiver is recommended.

Defaulters' Note Book of officials found responsible for excess/wrong payment during the year (year in which error was detected)

Sl. No.	Name & designation of officials responsible for overpayment	Nature of benefit paid	Ref. No. to B. O.	Amount of overpayment
1	2	3	4	5
Whether first, second or third etc., default by the same official during the year		Whether responsibility fixed	Nature of action taken	Remarks
6		7	8	9

11.48. The overpayments entered in the Excess Payment Register (in form ESIC-138) are not to be posted to the Defaulters' Note Book if recovery has been made before the case is referred for waiver. The said register (ESIC-138) provides a record which the Branch Manager should review from time to time to judge the nature and frequency of mistakes committed by different officials so that they can be suitably advised/cautioned, when necessary. The mistakes, whatever their nature and frequency, have to be viewed in the perspective of the total performance of the official concerned. If the extent and nature of mistakes is sufficiently indicative of negligence rather than casual slips, the case may be referred with full particulars to Regional Director for such action as he deems necessary.

11.49. Overpayments referred to Regional Office/Headquarters for waiver and, therefore, posted to the Defaulters' Note Book in the Regional Office will need special action in every case and responsibility has to be fixed, where it so warrants, for the loss occasioned to the Corporation. Nature and extent of responsibility of the various officials who dealt with the payment should be assessed in the first instance by the Branch Manager. From the angle of responsibility, overpayments fall into one or other of the following categories:-

- (a) Wrong payment or overpayment is a *bona fide* and isolated error by an official who, on over-all performance, is otherwise efficient. If the Branch Manager judges that a case falls in this category, he may in his recommendation for waiver to Regional Office, advise condonation of the error. Regional Director shall decide the question of responsibility in consultation with the Dy. Director (Finance) at Regional Office. If he accepts the recommendation of the Branch Manager, no warning or caution memo need be issued to the official concerned.
- (b) If excess payments or overpayments are made repeatedly by the same official – claims clerk, checker or other official - and disclose carelessness or lack of adequate sense of responsibility, which persists despite guidance and admonition from Branch Manager, full facts should be reflected in the annual confidential report of the defaulting official.
- (c) If the overpayment or excess payment discloses either *mala fides* or gross negligence on the part of the official, Branch Manager should report all the relevant facts to the Regional Director. In this category, cases of over/excess payments, where recovery has been made will also be included. The Regional Director, after preliminary investigation, shall decide whether there is sufficient material for instituting formal disciplinary proceedings and take further action accordingly.

11.50. It has been noticed that inspite of the above instructions, the number of cases of excess payments has been increasing and suitable action to recover the amount overpaid is very much delayed with the result that the Corporation is put to avoidable financial loss. Besides, very often overpayments are made by the same official, reflecting lack of adequate sense of responsibility,. It is, therefore, essential to obtain the explanations of the persons responsible for the overpayments immediately and to take action for fixing responsibility, if justified.

E. PROSECUTIONS

False declaration/representation

11.51. False statement or false representation by the insured person regarding abstention from work with a view to get cash benefit from the Corporation to which he is not eligible under the E. S. I. Act, amounts to an offence under Section 84 of the Act which, as now amended, reads as under:-

Section 84. Punishment for false statement. Whoever for the purpose of causing any increase in payment or benefit under this Act, or for the purpose of causing any payment of benefit to be made where no payment or benefit is authorised by or under this Act, or for the purpose of avoiding any payment to be made by himself under this Act or enabling any other person to avoid any such payment, knowingly makes or causes to be made any false statement or false representation, shall be punishable with imprisonment for a term which may extend to six months, or with fine not exceeding two thousand rupees, or with both.

Provided that where an insured person is convicted under this section, he shall not be entitled for any cash benefit under this Act for such period as may be prescribed by the Central Government.

The proviso appearing in the above Section as a result of the amendment of the Act, came into effect from 1.2.1991.

11.52. Central Rule 62 inserted as a follow-up of the said proviso says as under:-

Rule 62. Bar on grant of cash benefits: Where an insured person is convicted under Section 84 of the Act, he shall not be entitled to any cash benefit admissible under the Act for a period of three months for first conviction and six months for each subsequent conviction from the date of receipt of judgement of the court in the concerned office of the Corporation.

It has been held that the Rule above quoted applies to conviction of IP/IWs who wrongfully receive any of the benefits namely sickness benefit, extended sickness benefit, enhanced sickness benefit, temporary disablement benefit, maternity benefit and rehabilitation allowance (vide section B of Chapter XII of the Manual) and not to dependants' benefit, funeral expenses, medical bonus (confinement expenses) or conveyance charges/compensation for loss of wages, etc.

11.53. Prosecution should be launched in all cases where the amount of overpayment exceeds Rs. 50/- or the declaration covers an incapacity of more than 7 days, whichever is less. In all other cases, the insured person should be warned in writing and the amount involved recovered. In cases where wrong declarations are repeated, prosecution should be launched irrespective of the amount involved or the number of days of incapacity involved.

11.54. Appropriate cases of false declaration should be brought to the notice of the Trade Unions concerned tactfully, as it will have some good effect on insured persons in general.

11.55. The Regional Director should also bring to the notice of the employers, cases of wrong declarations made by their employees with a request to take disciplinary action. The cases in which insured persons are convicted by the court of law under Section 84, should also be brought to the notice of the employers concerned besides being displayed on the notice board of the Branch Office.

11.56. In cases where prosecution is to be launched under the above instructions and prosecution is desirable as a deterrent, no demand should be made for refund of the excess benefit paid until the criminal court gives its verdict. However, if the insured person of his own accord volunteers to refund the amount of excess benefit received by him, the same may be accepted but on the receipt issued to him it should be clearly mentioned that the refund is without prejudice to the action under Section 84 of the ESI Act. Similar remarks should also be given on counterfoil of the receipt and signatures of the insured person should be obtained on the counterfoil.

Impersonation for obtaining benefits

11.57. Impersonation is the act of pretending to be an insured person or beneficiary in his/her attempt to cheat the Corporation for obtaining cash benefits or the ESI dispensary for obtaining medical benefit.

11.58. For the first attempt at impersonation, the identity card should be retained and given back only after enquiries have been made and warning given to the insured person as well as to the impersonator. The Regional Director or the Branch Manager should, however, initiate prosecution even on the first attempt if they suspect *mala fides*. In all cases of impersonation, the identity card should be retained by the Branch Office. To avoid hardship to the insured persons in such cases, an intimation through the employer should be issued to the insured person to the fact that identity card bearing insurance no. has been seized in the Branch Office and its ownership is under investigation. If the insured person falls ill and wants his identity card, he should come to the Branch Office for issue of a receipt for the identity card on his establishing his identity. This receipt will be valid for a period of not more than three months and will be issued over the dated signature of the Branch Manager and with Branch Office stamp.

11.59. In case of a subsequent attempt, it should be examined as to whether there was a deliberate attempt at collusion and whether a case strong enough for conviction under the I. P. C. can be established. If so, the prosecution may be filed/conducted under the I. P. C. and a *post facto* intimation be sent to Hqrs. unless the Regional Director thinks that such action should, for any special reason, be not taken.

11.60. In the case of a third attempt, the insured person should be prosecuted under I. P. C. as a rule and immediately thereafter intimation sent to Hqrs.

11.61. In case an attempt at impersonation is discovered at the dispensary, it should be recorded on the medical record envelope with intimation to the Branch Office concerned. Such impersonation when intimated to the Branch Office or Regional Office, should be noted on the ledger sheet of the insured person who was impersonated and also on the ledger sheet of the person who impersonates if he happens to be an insured person.

Tampering with medical certificates

11.62.1. Where it is discovered that the insured person has tampered with a medical certificate, he should forthwith be prosecuted under Section 84 of the ESI Act even for the first offence.

11.62.2. Section 86(3) of the Act required prosecution under the Act to be filed within six months of the date on which the offence was alleged to have been committed. This time-limit has been removed by an amendment of the Act with effect from 20.10.1989. Despite this amendment, utmost promptness is required in filing prosecution complaints in cases of this nature under Section 84 of the Act so as to act as a deterrent for others.

11.62.3. In cases detected late, say, after six months from the date on which the offence of tampering of certificates took place, recourse may be had to file prosecution complaint under the Indian Penal Code.

11.63. It is usually difficult to sustain in the Court that the insured person himself tampered with the certificate unless an eyewitness to it deposes in the Court. Therefore, the charge to be preferred against the insured person should be that, with a view to secure higher benefit he produced and used a certificate which he knew to have been tampered with. This is also an offence under Section 84 of the Act and under the I. P. C. To substantiate it, the following evidence should be produced before the Court:—

- (a) The medical certificate showing over-writing or erasures.
- (b) The counterfoil or carbon copy of relevant certificates in the custody of IMO/IMP. As a matter of fact, this should be taken charge of before prosecution is launched, as this will be the main evidence in the case.
- (c) The declaration regarding abstention from work given by the insured person on the claim form. The fact that dates given in declaration tally with the altered dates on the certificates which has been tampered with, indicates that the insured person used the tampered certificate knowingly to obtain excess benefit.

11.64. The IMO/IMP who issued the certificate should, except where impracticable, appear in the court to testify. His statement may also be recorded before prosecution is launched.

11.65. Possibly, the insured person concerned might have also worked in the factory for the whole or part of the period for which benefit was claimed on a forged certificate. An on-the-spot abstention verification of his attendance in the factory or the wages received by him will be highly desirable.

11.66. Cases of other fraudulent practices, if they fit into section 84, may also be taken up for prosecution under that Section. Those cases of fraudulent practices which do not fit into the provisions of Section 84 may be prosecuted by taking recourse to the provisions of the Indian Penal Code. Sections 420, 468 and 471 of the Indian Penal Code which appear to be relevant, are appended below.

Sections 420, 468 and 471 of Indian Penal Code

Section 420. Cheating and dishonestly inducing delivery of property.— Whoever cheats and thereby dishonestly induces the person deceived to deliver any property to any person, or to make, alter or destroy the whole or any part of a valuable security, or anything which is signed or sealed, and which is capable of being converted into a valuable security, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Section 468. Forgery for purpose of cheating.— Whoever commits forgery, intending that the document forged shall be used for the purpose of cheating, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Section 471. Using as genuine a forged document.— Whoever fraudulently or dishonestly uses as genuine any document which he knows or has reason to believe to be a forged document, shall be punished in the same manner as if he had forged such document.

11.67. It may happen that an offence may attract both Section 84 of the Act and Section 420 or any other Section of the Indian Penal Code. If the offence is purely under Section 420 or other Sections of Indian Penal Code, care should be taken to make out the offence in such a way that it does not come within the purview of the ESI Act.

11.68. For prosecutions launched under Indian Penal Code, limitation as given in Section 468 (reproduced below) of Criminal Procedure Code, 1974 will apply :-

“468. Bar to taking cognizance after lapse of the period of limitation:

- (1) Except as otherwise provided elsewhere in the Code, no Court shall take cognizance of offence of the category specified in sub-section (2) after the expiry of the period of limitation.
- (2) The period of limitation shall be –
 - (a) six months, if the offence is punishable with fine only;
 - (b) one year, if the offence is punishable with imprisonment for a term not exceeding one year;
 - (c) three years, if the offence is punishable with imprisonment for a term exceeding one year, but not exceeding three years.”

11.69. Where a court imposes a fine, effort should be made to realise at least a part of the fine by pleading with the court that this money is meant for the amelioration of a poorer section of the society.

F. TIME-BARRED CLAIMS

Definition of time-barred claim

11.70. All claims submitted after 12 months from the date they became due for payment, come under the category of time-barred claims. The following criteria should govern the investigation and payment of all time-barred claims:-

- (i) The amount involved is not trivial.
- (ii) The reasons for delay in submission of claim are sufficient to justify excusal of delay.

- | | |
|--|--------------|
| 3. Funeral expenses | 15 days |
| 4. Temporary disablement benefit – first payment | One month |
| 5. Permanent disablement benefit – this also includes commutation payment – first payment. | One month |
| 6. Dependants' Benefit – first payment | Three months |

11.74. The Branch Manager and the Regional Director should ensure that the payments of benefit to insured persons are promptly settled and no unnecessary delay is caused. Any reference or clarification made/received should be promptly settled and delay avoided at all levels.

Watch over claims paid late

11.75. At the time of preparation of a claim for benefit, the claims clerk will examine the intervals between the date of payment and the date on which complete papers alongwith claim, certificates, etc., were submitted by the insured person. If the gap between the two dates exceeds the limits laid down, he will enter the details in the register under regulation 52, a proforma for which is suggested below:-

Sl. No.	Name of IP	Insurance No.	Nature of claim	Date of submission of claim
1	2	3	4	5
Date of payment		Extent of delay		Reasons for delay
6		7		8

A review of this register will enable the Branch Manager to keep a watch on the progress of payments and help him to ensure timeliness of delivery of cash benefits.

H. COMPLAINTS & GRIEVANCES OF ESI BENEFICIARIES

Procedure at Branch Office

11.76. A careful watch over the complaints arising out of the day-to-day working of the Scheme and expeditious disposal of these complaints is a key to its efficient functioning. Any laxity in their disposal tarnishes the Corporation's image. The following procedure has been laid down for the prompt and efficient disposal of complaints at Branch Offices for strict compliance at all levels:

- (1) The Manager of every Branch Office is designated as the Complaints Officer. A notice should be displayed at a prominent place in every Branch Office preferably in Branch language advising the beneficiaries to approach the Manager for their complaints/grievances regarding the Scheme.
- (2) A complaint box should be fixed at a prominent place in each Branch Office for complaints to be dropped into the box by the beneficiaries. The complaint box should be locked and the key should remain in the personal custody of the Manager.
- (3) The size of the complaint box shall approximately be as follows:

Back	44 cm X 30 cm
Front	40.5 cm X 30 cm (with an inlet of 20 cm length and a door of appropriate size, with a provision to lock the box.)
Side (at flat portion)	17.5 cm
Slanting top/flat bottom	COMPLAINT BOX of good quality wood/board or steel of appropriate thickness

In the top front portion, the words “COMPLAINT BOX” (or their equivalent) shall be written in English as well as in the Branch language.

- (4) The complaint box should be opened by the Manager every alternate day. A record of opening of complaint box should be maintained in the log book in the proforma at Annexure ‘A’. A monthly summary of the log book should be drawn up in the log book by the Manager as indicated in that proforma.
- (5) As soon as a complaint is received (through any source including complaint box), the same shall be entered in the Complaints Register (to be maintained as per proforma in Annexure ‘B’), a serial number shall be allotted to the complaint and an acknowledgement issued to the concerned complainant. A specimen of the acknowledgement to be sent may be seen at Annexure ‘C’.
- (6) It shall be the responsibility of the Manager to ensure that all complaints and grievances pertaining to cash benefit, are settled immediately at his level.
- (7) The complaints which are received in a Branch Office from the Regional Office should also be entered in the complaints register in red ink to enable the Manager to watch their early disposal. Replies to all complaints received from the Regional Office shall be sent to the Complaints Officer at the Regional Office who shall send these to respective branches for action where necessary.
- (8) In case complaint relates to medical benefit, BM will pass on the complaint to the Regional Director who will take up follow up action as narrated under the caption “Procedure at Regional Office”.
- (9) The Branch Manager shall submit a monthly report to Regional Director in respect of complaints received, settled and pending, with reasons of pendency. This shall be submitted in the proforma at Annexure ‘D’.
- (10) All inspecting officers visiting Branch Offices shall check compliance of these instructions by the Branch Offices and include their observations in their inspection reports.

Procedure at Regional Office

11.77. It seems relevant and necessary to detail out the procedure to be followed by the Regional Office regarding expeditious disposal of public grievances so that the Regional Office as well as the Branch Office function in harmony in this important matter:

- (1) The Regional Director shall act as Public Grievances Officer in the region through a Complaints Officer nominated by him. The Complaints Officer shall normally be a Joint Director/ Dy. Director. The Complaints Officer shall be available to hear the complaints/grievances of the beneficiaries for at least one hour every day. Action for ascertaining the facts, getting the complaints investigated, and settling the

complaint/grievance shall be taken by the Complaints Officer. He shall bring all important cases to the notice of Regional Director and take his orders where necessary.

- (2) A notice board with the name of the Complaints Officer should be displayed at a prominent and conspicuous place in the Regional Office directing the beneficiaries to approach the Complaints Officer for any grievance or complaint.
- (3) A complaint box of the size and specifications as in the case of Branch Offices, with the words COMPLAINT BOX painted in English as well as in the local language shall be fixed at a prominent place in the Regional Office and the key of the complaint box shall be kept in the personal custody of the Complaints Officer. The complaint box shall be opened by the Complaints Officer every alternate day and a record of the opening of complaint box shall be maintained in proforma in Annexure 'A'. A monthly summary shall be drawn up in the log book as indicated in the proforma.
- (4) All complaints and grievances, verbal or written, received by the Complaints Officer in the Regional Office (personally from employers/beneficiaries and dependants of the beneficiaries, through the complaint box or through Branch Office, etc.), should be entered in the complaints register to be maintained in the proforma in Annexure 'B'. Complaints/grievances received in different branches of the Regional Office direct, shall be acknowledged and action taken by the concerned branches.
- (5) While the complaints and grievances relating to the Corporation shall be dealt with and disposed of by the Regional Office, the complaints and grievances relating to medical benefit received direct or through Hqrs./Branch Office, etc. shall be forwarded to the Director/A.M.O., ESI Scheme of the State Government concerned for action except in Delhi/NOIDA where medical benefit is administered directly by the Corporation.
- (6) All complaints received from the Hqrs. Office shall be handled by the Complaints Officer. The same shall be entered in red ink in the complaints register to facilitate their quick disposal. Replies to complaints received from Hqrs. Office shall be sent to the concerned Officer at Hqrs. Office.
- (7) Complaints directly received at the concerned branches of the Regional Office shall not be forwarded to the Complaints Officer but shall be dealt with as per the existing procedure. However, on the first working day of each month, each branch shall send to the Complaints Officer, a monthly progress report in respect of the complaints received/pending. The report of such complaints be submitted in the proforma at Annexure 'E'.
- (8) To enable the Regional Director to keep a watch on the disposal of the complaints/grievances, the Complaints Officer shall submit to him a monthly statement of the complaints/grievances pending in the Regional Office, Branch Offices, etc. The Regional Director shall review the cases settled/pending and give appropriate instructions to the Complaints Officer. Where Hqrs. orders are necessary, he shall refer the matter to appropriate officer through a D.O. letter.
- (9) The Regional Director shall submit to the Director, Public Grievances, of Hqrs., a monthly statement in the proforma at Annexure 'E' by 5th of every month, indicating the position in respect of the previous month. The monthly statement shall reflect all the complaints received in the Region (i. e., by the Complaints officer, by the R. O. Branches direct, by the Branch Office, etc.), other than those on which Hqrs. has asked for information/report.
- (10) The superintendent/Head Clerk of the concerned branch at the Regional Office shall maintain a complaints register (Annexure 'B') for pursuing the complaints/grievances received in the branch from Hqrs., from the Complaints Officer of Regional Office as well as those received direct. Those received from Hqrs. shall be entered in red ink.

- (11) The dealing assistants in the branches at Regional Office shall enter complaints/grievances received from the Complaints Officer/Superintendent/Head Clerk of the branch, in red ink in their assistant diary and indicate their pendency in the weekly arrear reports to the Superintendent/Head Clerk and Branch Officer on the first working day of each month.
- (12) The Regional Director shall also establish a Facilitation Centre/Counter in the Regional Office, to receive complaints.
- (13) In case the complaints received pertain to medical side, the same shall also be entered in the complaints register. Regional Director shall then pass on the complaint to concerned Director (Med.)/A. M. O. of the State, with a copy to SMC. The SMC shall take up the matter relating to all complaints (whether received initially at Hqrs. or Regional Office or other Offices) with Director (Medical)/A. M. O. of the state. The Regional Director shall monitor the disposal of these complaints on fortnightly basis. In case any complaint remains pending for more than one month, he shall take effective steps for its disposal promptly. For this purpose, he shall discuss the matter with the State Government authorities/Director (Medical) and ensure timely action for disposal of the complaints pertaining to medical side. The Regional Director, SMC and Director (Medical) ESI Scheme shall meet once in a month to review/hear/settle the complaints relating to medical side.
- (14) In addition to above, information pertaining to number of complaints received, number of complaints settled and number of complaints pending (alongwith reasons) should be put up to the Regional Board in each meeting of the Regional Board and direction/advice of the Board obtained for gearing up the clearance of pending complaints.
- (15) Whenever the Regional Director is on tour to any particular place within the Region, he shall arrange a tripartite meeting with employers, beneficiaries and officials of medical profession to discuss and sort out any difficulties in providing benefits for the smooth functioning of the ESI Scheme.
- (16) The Regional Director shall also specifically mention in his monthly D. O. letter to the Director General about the complaints received, disposed of and pending in his region.
- (17) Complaints having vigilance angle shall be passed on for examination to concerned division/branch who will call for necessary information and settle the case preferably within one month. Any avoidable delay at any level will be liable for action. If, however, the complaint cannot be settled within the period of 3 months from the date of receipt, Regional Director may call for the requisite file and issue further directions to dispose of the complaint as per procedure laid down.
- (18) The procedure given above in respect of Regional Office shall also be followed at the Sub-Regional Office as well as at the Divisional Office. Head of the Sub-Regional Office as well as Divisional Office shall act as public grievance officer.

Log book of opening of complaint box

S. No.	Name, address & Ins. No. of complainant	No. & date, if any, of complaint	Brief particulars of complaint/ grievance	S. No. of complaint register to which the complaint transferred	Dated signature of complaints officer	Remarks
1	2	3	4	5	6	7

Date of opening of complaint box

Monthly summary

- (i) Number of days in the month on which complaint box opened
 - (ii) Number of complaints removed from complaint box during the month
-

REGISTER OF VERBAL/WRITTEN COMPLAINTS/GRIEVANCES

Sl. No.	Mode of receipt of complaint/ grievance. Whether through newspaper, telephone, through complaint box, by post, direct, etc.	Whether complaint/grievance verbal or written	Name, address & Ins. No. of complainant	No. & date, if any, of complaint/grievance	Brief particulars of complaint/ grievance	DETAILS OF ACTION							
						Name of officer to whom complaint/ grievance sent for action	Forwarding letter No. & date through which complaint/ grievance sent to officer concerned	Date of reminders to the Officer concerned	Date of receipt of reply/report	Date of final disposal of the complaint/ grievance	Brief particulars of remedy/ relief given to the complainant	Initials of Complaints Officer	Remarks
1	2.	3	4	5.	6.	7.	8.	9	10.	11	12	13.	14.
Monthly Summary													
i) No. of complaints brought forward													
ii) No. of complaints received during the month													
iii) No. of complaints finally disposed of during the month													
iv) No. of complaints pending at the end of the month													
(a) Upto one month													
(b) More than one month & upto three months													
(c) More than three months & upto six months													
(d) More than six months & upto one year													
(e) More than one year													
(f) Total													
													Complaints Officer

BRANCH OFFICE
EMPLOYEES STATE INSURANCE CORPORATION

No.

Date:

To

Subject: **COMPLAINT/GRIEVANCE – REGARDING**

Sir/Madam,

I am to acknowledge your complaint/grievance dated

The same has been registered under Sl. No.....in the Complaints Register and action is being taken thereon.

Please quote this letter number as well as the serial number of the complaint/ grievance, in all your future correspondence.

In case you do not receive any reply in the matter in a month, the undersigned may be contacted.

Yours faithfully,

Branch Manager

BRANCH OFFICE

Statement of pending complaints/grievances for the month ending to be submitted by Branch Manager to Complaints Officer, Regional Office/SRO

Sl. No.	No. of complaints brought forward from previous month	No. of days on which complaint box opened (as per log book of complaint box)	No. of complaints received during the month		No. of complaints finally disposed of during the month	
			From complaint box	Directly by B.M/ other sources		
1.	2.	3.	4.	5.	6.	
No. of cases pending for final disposal for						
less than one month	one month and more	three months and more	six months and more	1 year and more	Total	Details of cases pending final disposal for more than six months giving reasons for pendency in each case and action taken to settle the complaint
7.	8.	9.	10.	11.	12.		13.

Branch Manager

Note: The complaints forwarded by R. O./SRO etc., for investigation/ report shall not be reflected in this report

MONTHLY Progress Report of Complaints/Grievances for the month of _____

S. No.	No. of complaints/grievances pending at the end of previous month	No. of complaints/grievances received during the month	Total of (2) & (3)	No. of complaints/grievances disposed of during the month	No. of complaints/grievances pending at the end of the month						Remarks
					More than 1 Year	More than 6 Months	More than 3 Months	More than 1 Month	1 Month & less	Total	
1	2	3	4	5	6 (a)	6 (b)	6 (c)	6 (d)	6 (e)	6 (f)	7

(Signature with date)

Name of the Officer

Branch

Office

Note:

- (1) RO/SRO/Directors/Hospitals shall not reflect in this statement the complaints/grievances sent by Director (Public Grievances) or by other Officers/Branches of the Hqrs. Office.
- (2) Branches of Hqrs/RO/SRO/Directorates/Hospitals shall not reflect the complaints/grievances received from Director (Public Grievances)/Public Grievance Officer/Complaints Officer.

I. RECORD KEEPING, GRAPHS AND STATISTICS

Records in r/o claims and related matters

11.78. All relevant records in respect of claims including payment dockets and schedules will be maintained by the Branch Office in accordance with instructions on the subject.

11.79. All records and correspondence should be maintained in every Branch Office in subject-wise files, these being closed at the end of each calendar month, if necessary. The following subject-wise files may be maintained:

<i>S. No.</i>	<i>Name of document</i>	<i>To be maintained</i>	<i>Remarks</i>
1.	Sanction for investigation of time-barred claims.	Date-wise	
2.	Funeral expenses, correspondence on.	Date-wise	
3.	ESIC-47 (Correspondence relating to ESB rate).	Ins. No. wise	
4.	Temporary disablement benefit (employment injury cases).	Date-wise with cross reference to Accident Report Register	Report and ESIC-32 will be kept with the claims clerk in a separate folder of "Accepted employment injury cases pending for payment", till the payment is claimed. After payment, these papers will be rubber stamped "Cancelled", and filed in a separate folder of "Employment Injury paid Cases", in chronological order according to date of payment.
5.	New Form 10- replies to	Date-wise according to date of reply, with cross reference to entries in ESIC-60 register(See Annexure V)	Cases in which excess payment is detected will be entered on the ledger sheet at the appropriate place in the remarks column indicating also the relevant S. No. of the excess payment register. However, entry regarding mere issue of Form 10 need not be made on the ledger. This shall be watched through ESIC-60 register and entry made in ledger only in case of detection of excess payment. ESIC-60 register should, however, indicate the dates for which abstention enquiry was initiated.
6.	Correspondence relating to complaints regarding alternative evidence	Date-wise	

7.	Incapacity reference in form RM 1 (M) & RM 1(P)	Date-wise	Register of incapacity references will continue to be maintained.
8.	Confinement expenses (correspondence with Regional Office)	Date-wise	
9.	Alternative evidence rejected (alternative evidence certificates)	Date-wise	
10.	Folders of certificates of non-eligible and exhausted cases (month-wise).	Ins. No. wise	
11.	Folders of pending certificates	Ins. No. wise	Please see para P.3.39 of Chapter III – General Claims Procedure in this connection
12.	Miscellaneous file	Date-wise	
13.	ESIC-71	Date-wise.	With cross reference to S.No. in ESIC – 71 register.
14.	Folder for claims passed but not paid (with Cashier).	Ins. No. wise	

11.80. During working hours of the Branch Office, ledgers should be kept in a rack/cabinet by the side of the counter clerk from where these can be picked up and replaced. At the close of the day the ledgers should be kept under lock and key for safe custody.

Visual record of payments etc.

11.81. With a view to keeping control on the working of the Branch Office and to watch the trend of incidence of benefits, the Branch Manager should maintain and display visual record in the shape of charts and graphs. This may be of such size as may be considered necessary for facile presentation of the position, but charts of size 55 cm X 76 cm (22" X 30") have been found useful and convenient.

11.82. For this purpose the Branch Office should maintain :-

- (1) Central statistical register;
- (2) Statistical chart;
- (3) Sickness benefit (including extended sickness benefit) graph;
- (4) Temporary disablement benefit graph.

Central statistical register

11.83. A specimen of the form of this register may be seen at Annexure VIII. This is an important register of the Branch Office which shows at a glance almost all the important activities of the Branch Office as well as the daily trends of certification and benefits. A Manager who keeps an intelligent eye over the day-to-day figures recorded in it, can easily read the adverse trends and where necessary take timely remedial action to arrest them.

11.84. The method of filling up some important columns is described below:-

- (1) Against the column "Total average daily number of payments for the preceding year", enter the figure arrived at by dividing total number of payments recorded in previous financial year by the total number of actual working days, upto two decimal places.
- (2) Against the column, "Number of employees" enter the approved number of employees for your centre/Branch Office intimated by the Regional Office at the beginning of the year. If this is not available, enter the figure for your centre as communicated in the statistical brochure if since received. The number of insured persons is arrived at by multiplying the approved number of employees with the factor for the state provided by Headquarters in the statistical brochure.

11.85. Most of the figures for this register will be available from the daily schedule sheets, the certificate diaries and other registers maintained in the Branch Office and there should be no difficulty in filling in the columns against each date. Care should, however, be taken that this work never falls into arrears, because once that happens, the Manager will not only find it difficult to bring it up-to-date but will also have lost the opportunity of watching the trends in certification and payments and would thus have failed in the all-important function of keeping control.

11.86. At the close of a month, when total of various columns have been struck, the following important calculations will need to be done:-

$$\begin{array}{l} \text{Average number of certificates per 1000} \\ \text{employees} \end{array} = \frac{\text{Total number received x 1000}}{\text{Approved No. of employees}}$$
$$\text{Average amount per 1000 employees} = \frac{\text{Total amount paid x 1000}}{\text{Approved No. of employees}}$$
$$\begin{array}{l} \text{Incidence of sickness/extended} \\ \text{sickness/temporary disablement benefit} \\ \text{(separately for each benefit)} \end{array} = \frac{\text{Total No. of days of sickness/extended} \\ \text{sickness/temporary disablement benefit x 12}}{\text{Approved No. of employees}}$$

All calculations will be done to two decimal places.

Statistical chart

11.87. The incidence of sickness/extended sickness/temporary disablement benefits per employee per annum as recorded for each month in the central statistical register will be posted in the statistical chart (specimen at Annexure IX) in the relevant monthly column. Further, the amount of each benefit per 1000 employees will also be posted in column 3, 5, 7, 9, 11, 13 and 15 of the chart. The percentage of incapacity references to be indicated will be with reference to the number of payments recorded under sickness benefit, extended sickness benefit and temporary disablement benefit, the percentage of abstention verification will be with reference to the total number of terminated cases of the aforesaid three benefits as well as maternity benefit. While the number of first three categories of the terminated cases can be gleaned from the central statistical register-(columns 39, 41 & 43), the number of terminated cases of maternity benefit can easily be determined, there being not many cases every month. For a Branch Office which has

decentralised registration work, columns 28 & 29 have been provided in the statistical chart to indicate the number of declaration forms received and the number in respect of which documents have been prepared and despatched. At the close of the financial year, totals will be struck in the columns provided and the monthly average will be worked out and written under the various heads. The figures so arrived at will be posted in the next year's statistical chart in the space provided for the purpose in the first row, so as to allow ready comparison with the current year's performance on month-to-month basis.

11.88. Depending upon the convenience of the Branch Office and for having a better visual display, it would be preferable to split up the information to be depicted in the Statistical Chart into two separate charts – Statistical Chart No. 1 and 2. Chart No. 1 may comprise columns 1, 4-15 and 18-21 and chart No. 2 may incorporate the remaining columns and repeat column 1.

Graphs

11.89. To have an idea of the trend of payments at a glance, every Branch Office should maintain two graphs on graph paper of size say 55 cm X 76 cm (22" X 30"), properly mounted, one for sickness benefit and the other for temporary disablement benefit. Both graphs should exhibit total amount (in thousands) as well as the number of payments of the respective benefit as recorded from month to month during financial year April to March. Since two distinct quantities are to be shown, separate inks should be used to depict them. The quantities may be shown by means of rectangles of two distinct colours, the rectangle for the amounts being shown in red colour and that for the number of payments may be shown in blue colour. Specimen of the graphs may be seen at Annexure X and XI.

All India incidence of SB and TDB

11.90. All India incidence of sickness benefit and temporary disablement benefit is given hereunder for information and guidance :-

No. of benefit days per employee per annum

<i>Year</i>	<i>Sickness benefit</i>	<i>Temporary disablement benefit</i>
1980-81	8.00	1.19
1981-82	8.50	1.44
1982-83	7.60	1.39
1983-84	7.18	1.54
1984-85	6.12	1.42
1985-86	4.99	1.12
1986-87	4.95	1.16
1987-88	4.38	1.07
1988-89	3.71	0.97
1989-90	3.30	0.86
1990-91	2.42	0.76
1991-92	2.36	0.65

1992-93	2.19	0.81
1993-94	2.85	0.86
1994-95	2.51	0.80
1995-96	2.07	0.71
1996-97	1.83	0.55
1997-98	1.68	0.51
1998-99	2.07	0.54
1999-2000	1.93	0.52
2000-2001	1.93	0.50
2001-2002	1.91	0.53
2002-2003	1.77	0.53
2003-2004	1.80	0.53
2004-2005	1.55	0.44
2005-2006	1.34	0.38
2006-2007	1.12	0.32
2007-2008	0.98	0.30
2008-2009	0.94	0.23

J. RECORDS MANAGEMENT AT THE BRANCH OFFICE

Importance

11.91. Proper management of records at the Branch Office is one of the most important aspects of its efficient functioning but one to which scant attention is paid. A good and clean Branch Office is one where every record is kept in its place, is regularly dusted and is weeded out the moment it is no longer required. Every Manager should make it a habit to manage his records and to have a definite record weeding out programme keeping in view Hqrs. instructions contained in the compilation named "Records Retention Schedule" and other instructions issued from time to time.

Retention periods of records

11.92. Keeping in view the requirement of Branch Office, the retention periods of the records are provided hereunder for ready reference :-

<i>Subject Matter</i>	<i>Retention Period</i>	<i>Remarks</i>
A. Administration:		
1. Sanction of casual leave/spl. Casual leave/restricted holiday of employees.	(a) Casual leave: to be destroyed at the end of the year (b) Special casual leave: 1 year	
2. Grant of periodical increment	Permanent	
3. Earned leave – grant of	3 years	
4. Delegation of powers to Manager/other functionaries.	Permanent	
5. Advances to employees	1 year	
6. Forwarding applications of employees	1 year	
7. Progressive use of Hindi in Corporation – general aspects	Permanent	
8. Grievances/representations of employees	10 years	
9. Hiring of office accommodation	3 years or 1 year after completion of audit or 1 year after termination of lease/contract whichever is the latest	
10. Furniture, steel equipment, etc. – purchase, hiring maintenance and repairs and condemnation	3 years or 1 year after completion of audit whichever is later	Subject to suitable entries being made in the appropriate register
11. Stationery & forms – supply of	1 year	
12. Specification of forms	Permanent	
13. Office bicycles – purchase, repair, maintenance & condemnation	3 years or 1 year after completion of audit whichever is later	Subject to suitable entries being made in (I) appropriate stock register and (ii) register for watching progress of expenditure on maintenance and repairs
14. Telephone file	3 years or 1 year after completion of audit whichever is later	

B. Cash & Accounts

- | | | |
|---|---|--------------------------|
| 1. Cash book A/C No. 1 & 2 | Permanent | |
| 2. Benefit payment schedules with Finance & Accounts Branch ESIC-19 (known as MISLO – 01) and ESIC – 20 | 6 years | |
| 3. Daily cash return A/C No. 2 | 6 years | |
| 4. Monthly cash return A/c No. 1 & 2 | 10 years | |
| 5. Stock registers of receipt books. | 5 years | After last entry therein |
| 6. Counterfoils of receipt books. | 5 years | |
| 7. Counterfoils of cheque books | 5 years | |
| 8. Imprest cash book | Permanent | |
| 9. Transfer of funds file | 2 years after the period of external audit has expired | |
| 10. Establishment pay bills-vouchers | 35 years | |
| 11. Vouchers of advances to employees | 6 years | |
| 12. Files containing schedules of benefit payments at Branch Office (ESIC-19 and ESIC-20) | 3 years after close of month provided there is no pending audit objection or a court case | |

C. Insurance & Benefits

- | | |
|---|---|
| 1. False declaration and other miscellaneous correspondence where decision already taken, including form 10 register. | } 3 years from the date of last entry provided there are no audit objections and no cases are pending in a court of law |
| 2. Statement of waiver of recoveries. | |
| 3. Time-barred claims decided finally. | |
| 4. Papers relating to claims for sickness benefit, temporary | |
-

	disablement benefit claims, including correspondence.		
5.	RM-1 register and correspondence on incapacity references.	As above.	
6.	Accident report register	5 years from the date of last entry	
7.	Claims diary	-do-	
8.	Register of alternative evidence	-do-	
9.	Excess payment register	3 years from the date of last entry provided all outstanding recoveries are effected by the time and no audit objection or court case is pending	
10.	ESIC-61: Branch Office register of references to the Medical Board	5 years from the date of last entry subject to finalisation of audit objections	
11.	ESIC-156 register for recording claims of conveyance charges and/or compensation for loss of wages for appearing before Medical Board/Medical Referee/Medical Appeal Tribunal	3 years from the date of last entry subject to finalisation of audit objections	
12.	Money order acknowledgements	3 years from the close of financial year to which they relate provided no audit objections/court cases are pending	
13.	Ledger-sheets	5 years if no benefit payment has been made during the period (except where audit objection exists) and IP is not entitled to medical benefit.	.See also para 1.82B
14.	Permanent disablement benefit registers	20 years from the date of last payment.	See also para P.5.76
15.	ESIC-72/72-A	3 years	
16.	ESIC-71	3 years	
17.	Insurance number allotment register	Permanent	

18. ESIC-54	3 years	
19. Return of Contributions	3 years after end of benefit period to which they relate, provided no audit objection/court case is pending	
20. Envelopes received from ESI Dispensary at Pay Office, containing medical certificates issued to IP, towards reimbursement of expenses incurred on postage	Until internal and external audit is conducted and no audit objection is pending.	
21. Paid certificates under ledger system tagged with payment dockets (inclusive) or unpaid regulation certificates or those on which benefit has not been claimed or paid	3 years from the close of financial year to which they relate.	Exception: Such records as are under audit objection by internal/external audit or where any legal case is pending should be preserved.
22. Declaration Forms	20 years from the date of allotment and subject to no claim of cash benefit for the last 5 years and exit from ESIC-38 register during the last 5 years.	

Record of papers weeded out

11.93. A record of the papers, documents, registers, files weeded out should be kept in the following proforma. In column 3 of this register, only the total number of dockets, alternative evidence cases, complaint cases, etc., destroyed in respect of the period shown in column 5 should be indicated. These records will be destroyed under the personal supervision of the Branch Manager.

Sl. No.	Nature of documents	Particulars	Volume or total number of pages
1	2	3	4
Period to which the records relate		Date of destruction	Dated signatures of the officer instructing the destruction
From	To		Remarks
5(a)	5(b)	6	7
			8

EMPLOYEES' STATE INSURANCE CORPORATION

Incapacity References from Mofussil Areas

From: To:

Manager,
.....
.....

Medical Referee

Sub: Incapacity reference of insured persons

Sir,

I have to refer to you for medical examination the following insured persons. The date of medical examination as fixed/as may be fixed by you has been/will be intimated to the insured persons and the IMO/IMP concerned.

Table with 10 columns: Sr. No., Name, Ins. No., Name of dispensary or I. M. P. to whom attached, Date and form of last certificate received, Cause of abstention stated in the certificate, Date of first certificate, No. and date of final certificate issued, M. R.'s reference No., Remarks.

Date of examination for above noted cases is

Yours faithfully
MEDICAL REFEREE

Manager, Branch Office,

Manager

R. M. 1(P)

ANNEXURE III
(See para 11.7)

EMPLOYEES' STATE INSURANCE CORPORATION

Incapacity References

Branch Office
Stamp.....
No.
Dated

Sir,

I am herewith referring to you for medical examination at your office on at the following insured persons.
The insured persons and the Insurance Medical Officers have also been informed.

Sl. No.	Name of insured person	Insurance number	Name of the dispensary/ IMP	Date of last certificate received	Cause of abstinence stated in the certificate	Date of first certificate in present illness	Insurance Medical Officer's brief notes	Remarks
1	2	3	4	5	6	7	8	9

To

Civil Surgeon

Copy to IMO Incharge dispensary with the request to inform the insured person(s) if attending the dispensary and to complete Column-8 and send it direct to the Civil Surgeon so as to reach before the date of examination indicated above.

Branch Manager

EMPLOYEES' STATE INSURANCE CORPORATION

Claim for conveyance allowance and/or compensation for loss of wages from an insured person who appeared –

(a) before a Medical Board/at a Hospital/Dispensary/diagnostic centre for assessment of Permanent Disablement.

OR

(b) before a Medical Authority under Regulation 71 (1) on (date)

A.

Name
Father's/husband's name
Ins. No
Address.....
Name and address of the present/last employer
.....

B. To be filled in by the employer

Certified that Shri Insurance No is in my employment and on account of his attending the dispensary/diagnostic centre/Hospital or on account of his appearance before the Medical Board/Medical Authority, he will lose/lost wages for days at Rs. per day on (dates).

Date

Signature of the employer

Name and code no. of the factory/estt.

C. To be filled in by the employee

I hereby declare that I have not been/shall not be at work sinceAM/PM on the and that I have not and will not receive leave wages for the day from my employer.

I claim reimbursement of loss of wages.

Note: Half day or less than a half day should be counted as a half day and more than half a day as one day.

Signature of the employee

Insurance No.....

D. To be filled in by the Chairman of Medical Board/Medical Authority

1. Was the insured person present?
2. Was the insured person in your opinion fit to attend at the dispensary?
3. Was he, in your opinion, unable to travel by bus or other ordinary means of conveyance or did he need an attendant to accompany him?
4. Was he in your opinion unable to travel in a sitting position?
5. Was he referred to the hospital/ dispensary/diagnostic centre with a view to assessing the permanent disablement by the Medical Board?

E. To be filled in by the Head Clerk/U. D. C. Incharge

Amount admissible:

Rs.

Ps.

(a) Wagesday (s) at Rs.Ps.per day

(b) Amount spent on fare from to
(Bus/Second class)

(c) Return fare

(d) Total amount admissible

(e) Received Rupees

Signature or thumb impression of insured person

Paid in my presence

Chairman Medical Board/Medical Authority.

Countersigned:

Regional Director/Deputy Regional Directory/Assistant Regional Director/Branch Manager.

.....BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

No.....

Dated.....

To

.....
.....
.....

Subject: Recovery of excess amount paid to Shri Ins. No
.....

Dear Sir,

I have to state that the above-named insured person has received an amount of Rs as sickness benefit/temporary disablement benefit under the Employees' State Insurance Act, 1948 to which he was not entitled by reason of

I have therefore to request that part A of this form may please be detached and handed over to him and his acknowledgement may please be obtained and forwarded to this office in part B of this form.

I have also to request you to kindly direct the insured person to visit this Branch Office to refund the above amount immediately failing which the same will be recovered from him as arrears of land revenue as laid down under Section 70 and Sections 45B to 45-I of Employees' State Insurance Act, 1948 and he may also be prosecuted under Section 84 of the said Act.

Your co-operation in the matter will be highly appreciated.

Yours faithfully,

Manager

Contd.....

'A'

Letter for the insured person

BRANCH OFFICE.....
EMPLOYEES' STATE INSURANCE CORPORATION

Ref. No. ESIC-96

Dated

Insured person Ins.
No.

--	--

Dear Sir,

According to declaration dated given on claim/certificate No. you have declared that you did not work from to on account of incapacity and that you had not drawn any wages for leave or for holidays from your employer. However, on verification, it has been noticed that you have worked in the factory from to and that you have also drawn wages from your employer for days of paid leave and holidays. You have thus obtained excess payment by making false declaration. This is an offence punishable under the ESI Act, 1948. Please refund Rs. received on account of excess payment for days and deposit the amount by in this Branch Office.

You should also show cause as to why action under Section 84 of the ESI Act should not be taken against you for making false statement.

Yours faithfully,

Branch Manager

'B'

Acknowledgement from the insured person

The Manager
Branch Office

(to be returned by the employer to Branch Office)

Dear Sir,

I hereby acknowledge the receipt of your letter No. ESIC-96 dated asking for repayment of drawn by me in excess.

Yours faithfully,

Dated

Signature.....

Name.....

Ins. No.....

QUARTERLY STATEMENT OF EXCESS PAYMENTS FOR THE QUARTER ENDED

.....200.....

Sl. No.	Name of the Branch Office	AMOUNT OF EXCESS PAYMENTS					REMARKS
		In the beginning of the Quarter	Detected during the Quarter	Total	Recovered/Adjusted/Waived Off during the quarter	Balance at the end of the quarter	
1.							
2.							
3.							
4.							
5.							
6.							
	Total						

**REGIONAL/SUB-REGIONAL OFFICE
ESI CORPORATION**

.....

No.

Dated.

Forwarded to the Director General (Benefit Branch II), ESI Corporation for information and necessary action. This refers to their letter No. R.18.13.Policy/89-Bft II dated 21.03.07

(
R.D./J.D. (I/c))

Total average daily number of payments for the preceding year

ANNEXURE VIII
(See para 11.83)

Month.....
Year.....

CENTRAL STATISTICAL REGISTER
BRANCH OFFICE

No. of employers		No. of employees	
		No. of insured persons	

Date	First Certificates including first & final (combined) received	Subsequent certificates received	S. B.			E. S. B.				T. D. B.				M. B.			P. D. B.			D. B.					
			No. of payments	No. of benefit days	Amount	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount	No. of fresh claims on which payments made	No. of payments	No. of benefit days	Amount	No. of fresh claims on which payments made			
1	2		5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
1 to 15																									
Total																									
16 to 31																									
Mon-thly Total																									
Total benefit days			Total number of payments.....							Total amount															

Benefit days per 1000 employees.....	Average certificates per 1000 employees	Amount per 1000 employees
--------------------------------------	---	---------------------------------

Commutati on		Funeral expenses		M. O.		Other Benefits	Total		M. O.		Exhausted/Terminated Cases						Issue of				
No. of cases	Amount	No. of payments	Amount	Commission	Cost of M. O. forms		No. of payments	Amount	No. of payments	Amount of benefit	S. B.		E. S. B.		T. D. B.		R. M. I.	Form-28/28A	ESIC-71		
											No. of cases	No. of days	No. of cases	No. of days	No. of Cases	No. of days					
28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47		
1 to 15																					
Total																					
16 to 31																					
Mo-nthly Total									INCIDENCE OF										DAILY AVERAGE		
										S. B.		E. S. B.		T. D. B.							

ANNEXURE IX
(See para 11.87)

As on

STATISTICAL CHART
BRANCH OFFICE
YEAR

No. of employers		Approved No. of employees	
		No. of insured persons	

MONTH	Average no. of certificates per 1000 employees	Amount per 1000 employees	S. B.		E. S. B.		T. D. B.		M. B.		P. D. B.	
			No. of benefit days per 1000	Amount per 1000	No. of benefit days per 1000	Amount per 1000	No. of benefit days per 1000	Amount per 1000	No. of benefit days per 1000	Amount per 1000	No. of benefit days per 1000	Amount per 1000
1	2	3	4	5	6	7	8	9	10	11	12	13
B. O. average pm. for previous year												
April												
May												
June												
July												
August												
September												
October												
November												
December												
January												
February												
March												
Total												
Monthly Average												

Statistical Chart – contd.

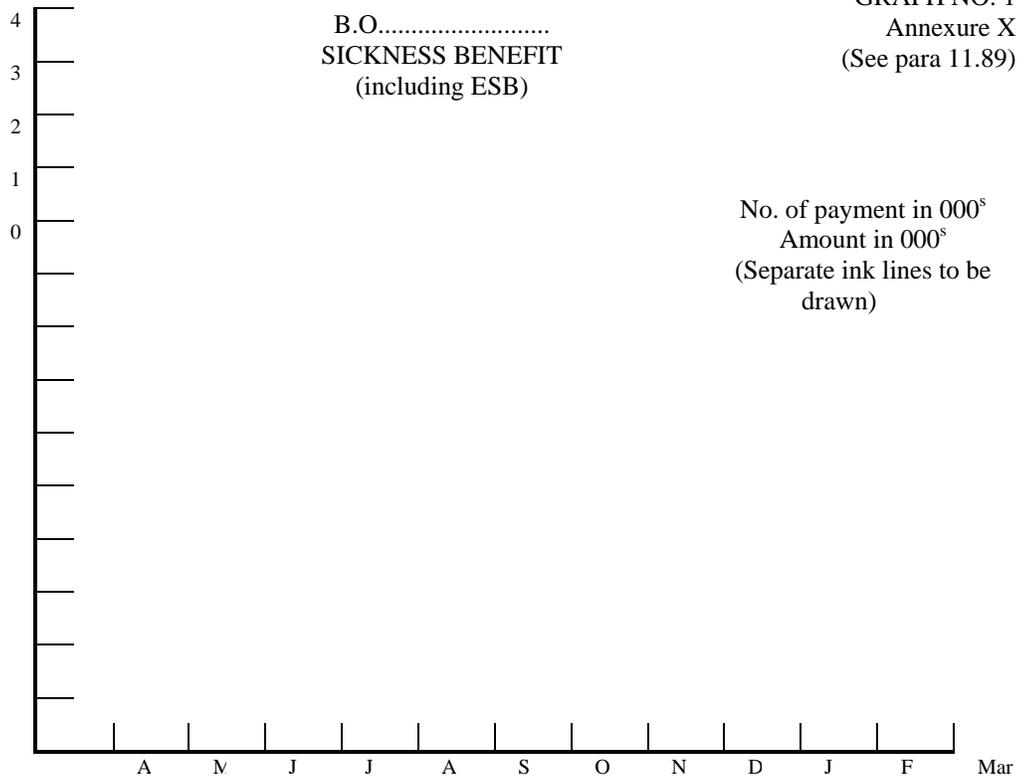
	D. B.		M. O.		COMMUTATION		FUNERAL EXPENSES		ACCIDENT REPORTS							
	No. of benefit days per 1000	Amount per 1000	No. of cases	Amount	No. of cases	Amount	No. of cases	Amount	Received	Admitted	Rejected	Investigated	% of incapacity references	% of abstention verification	No. of D. Fs. received	No. of IPs in respect of whom documents prepared/despached
	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
BO average pm. for previous year																
April																
May																
June																
July																
August																
September																
October																
November																
December																
January																
February																
March																
Total																
Monthly Average																

B.O.....
SICKNESS BENEFIT
(including ESB)

GRAPH NO. 1
Annexure X
(See para 11.89)

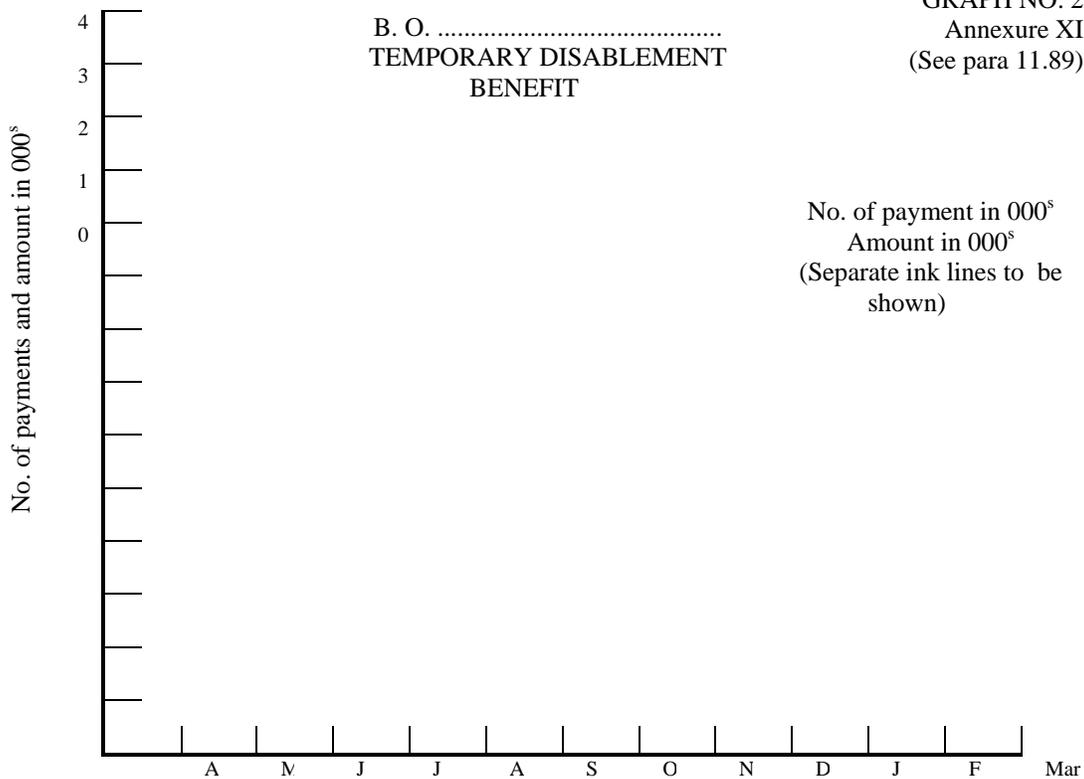
No. of payments and amount in 000^s

No. of payment in 000^s
Amount in 000^s
(Separate ink lines to be
drawn)



B. O.
TEMPORARY DISABLEMENT
BENEFIT

GRAPH NO. 2
Annexure XI
(See para 11.89)



CHAPTER XII
OTHER IMPORTANT MATTERS
CONCERNING IPs AND THEIR FAMILIES

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CHAPTER XII

OTHER IMPORTANT MATTERS CONCERNING IPs AND THEIR FAMILIES

Introduction

The Corporation has set up Branch Offices all over the country and cash benefits under the Act are being disbursed at these Branch Offices. Insured persons visit these Branch Offices and often seek guidance on various matters connected with their insurance cover. A majority of them are generally unaware about various provisions due to their low literacy level and a well-informed BM and his staff must effectively help and guide them in times of their adversity resulting from sickness, disablement, etc. Certain matters concerning insured persons and their families, apart from benefits admissible to the IPs, which do not find a place in the 11 foregoing Chapters, and which have been evolved/resolved upon by the ESI Corporation in its pursuit of the noble objective of providing comprehensive social security are listed below: -

- A. Medical care to permanently disabled and retired insured persons.
- B. Vocational Rehabilitation Scheme for permanently disabled insured persons.
- C. Confinement expenses for IW/IP's wife.
- D. Artificial limbs for amputee IPs and family members.
- E. Rajiv Gandhi Shramik Kalyan Yojna (w.e.f. 1.4.2005)
- F. Vocational Rehabilitation Skill Development Scheme under Rajiv Gandhi Shramik Kalyan Yojna

Detailed information on each of these matters is provided in this Chapter so that BM and his staff can guide and help the IPs as well as their family members in case of need and also make payment of the relevant benefit, where admissible. BM's knowledge of these topics will also be helpful to IMOs in providing the benefits with which they are directly concerned but need guidance.

A. MEDICAL CARE TO PERMANENTLY DISABLED AND RETIRED INSURED PERSONS.

Provisions in the Act

12.A.1. The ESI Act was amended in 1989 and the following two provisos were added to sub-Section (3) of Section 56 – Medical Benefit, with effect from 1.2.91:

Provided further that an insured person who ceases to be in insurable employment on account of permanent disablement shall continue, subject to payment of contribution and such other conditions as may be prescribed by the Central Government, to receive medical benefit till the date on which he would have vacated the employment on attaining the age of superannuation had he not sustained such permanent disablement:

Provided also that an insured person, who has attained the age of superannuation, a person who retires under voluntary retirement scheme or takes premature retirement and his spouse shall be eligible to receive medical benefit, subject to payment of contribution and such other conditions as may be prescribed by the Central Government.

Explanation: In this section, 'superannuation', in relation to an insured person, means the attainment by that person of such age as is fixed in the contract or conditions of service as the age on the attainment of which he shall vacate the insurable employment or the age of sixty years where no such age is fixed and the person is no more in the insurable employment.

Provisions in the Central Rules

12.A.2. As a follow up of the above amendment, new Rules 60 & 61 were added to the ESI (Central) Rules, 1950, and the same are reproduced below for ready reference:

60. Medical benefits to insured person who ceases to be in an insurable employment on account of permanent disablement

An insured person who ceases to be in an insurable employment on account of permanent disablement caused due to an employment injury shall be eligible to receive medical benefit for himself and his spouse at the scale prescribed under the Act and the regulations made thereunder till the date on which he would have vacated the employment on attaining the age of superannuation, had he not sustained such permanent disablement, subject to –

- (i) the production of proof by such an insured person that he ceased to be in an insurable employment on account of permanent disablement due to employment injury to the satisfaction of such officer as may be authorised by the Corporation; and
- (ii) the payment of contribution at the rate of ten rupees per month in lump sum for one year at a time in advance to the concerned office of the Corporation in the manner prescribed by it.

61. Medical benefits to retired insured person

An insured person who leaves the insurable employment on attaining the age of superannuation after being insured for not less than five years, shall be eligible to receive medical benefits for himself and his spouse at the scale prescribed under the Act and the regulations made thereunder, subject to –

- (i) the production of proof of his superannuation and having been in the insurable employment for a minimum of five years to the satisfaction of such officer as may be authorised by the Corporation; and
- (ii) the payment of contribution at the rate of ten rupees per month in lump sum for one year at a time in advance to the concerned office of the Corporation in the manner prescribed by it.

Provisions in the Regulations

12.A.3. As for the procedure to be followed, the Corporation has framed Regulation 103-B of ESI (General) Regulations, 1950 which reads as under:

103B. Medical benefit to insured person who ceases to be in insurable employment on account of permanent disablement.

- (1) An insured person who ceases to be in insurable employment on account of permanent disablement caused due to employment injury shall continue to receive medical benefit for himself and his/her spouse till the date on which he would have vacated the employment on attaining the age of superannuation had he not sustained such permanent disablement, if he produces a certificate from the employer/a declaration in the form which may be specified by the Director General for the purpose.
- (2) **Medical benefit to retired insured persons** – An insured person who has attained the age of superannuation shall be eligible to receive medical benefit for himself and his/her spouse, if he produces a certificate from the employer in the form which may be specified by the Director General for the purpose.

- (3) An employer shall, on demand, issue the certificate as referred to in sub-regulations (1) and (2) to an employee who had been employed by him.

Interpretation

12.A.4. A study of the above-quoted provisions will reveal certain important aspects of this benefit, which are explained as under:-

- (1) 'Superannuation' can be at an age less than 60 years for those whose contract or conditions of service provide for a superannuation age to be less than 60 years. Further, this benefit is admissible only to one (i) who is an "insured person" leaves insurable employment on attaining the age of superannuation.
- (2) For claiming facilities provided as part of medical benefit, there is no distinction between a regular entitled IP and a permanently disabled or superannuated person, except that super-specialty treatment will not be admissible to such persons and their spouses.
- (3) For entitlement to medical care, a permanently disabled IP or a superannuated IP must pay in advance of Rs. 120/- as contribution for a full year normally to the Manager of the Branch Office to which the factory/establishment where he last served was attached.
- (4) No member of the family other than the spouse shall be eligible to this benefit. However, the person and his/her other members of the family will possibly remain entitled to medical care by virtue of his/her having paid contributions as an "employee" under the Act for some limited time after he/she leaves employment. He/she can avail of this advantage at his/her option before joining the new medical scheme for superannuated/permanently disabled employees.
- (5) A permanently disabled person will be eligible for this benefit till he attains the age of superannuation provided he/she continues to pay the annual fee of Rs. 120/- in advance.
- (6) On reaching superannuation age such a permanently disabled person can continue to be a member but only as a superannuated IP if he furnishes proof that contributions were paid in respect of him as an 'employee' under the Act for not less than 5 years.
- (7) A superannuated IP is entitled to this benefit irrespective of the fact that part of his service as 'employee' was rendered in another region. The period of service as an 'employee' need not be continuous.
- (8) On the death of such a person, his/her spouse will continue to be entitled to medical care upto the date he/she would have been entitled had he/she been alive.

Procedure to be followed

12.A.5. Branch Manager should give wide publicity to this Scheme by various ways, e.g., notice board, contact with IMOs, employers, employees' unions, etc. When the IPs of these two categories approach the concerned Branch Office for registration, for payment of fee and for entitlement to medical care, the procedure as detailed below will be followed :-

- (1) The applicant shall submit an application to the Branch Manager in form at Annexure 'A', alongwith a certificate at Annexure 'B' and a declaration in the form at Annexure 'C' duly filled in and signed by the applicant.
- (2) The Branch Manager will verify the contents of the documents from the records of the Branch Office and make sure that the applicant satisfies the eligibility conditions for receiving medical benefit under this Scheme. The IP's contribution will then be received in cash for

which receipt will be issued to the applicant. The BM will then record his order on the form prescribed on the reverse of the application (Annexure 'A').

- (3) In case the insured person is not found eligible to medical benefit, he shall be informed in writing in the form at Annexure 'E' indicating the reasons for which his application has been rejected. In such an event, no contribution will be collected from the applicant.
- (4) The applicant, on being admitted, will surrender his old identity card and he shall be issued a fresh identity card for himself and his spouse on top of which shall be written/stamped 'VALID UPTO _____'. The new identity card will bear his old insurance number. A new MRE shall also be prepared which shall also be written/stamped 'VALID UPTO _____'.
- (4A) If such a person loses his identity card or needs replacement of the old and dilapidated one, procedure as given in Para 1.88 for issue of duplicate identity card shall be followed mutatis mutandis.
- (5) The period of validation shall be the period for which the insured person has paid the contribution.
- (6) The MRE will be sent to the IMO incharge of the concerned dispensary under ESIC 48-A (Annexure 'D'). Copies of ESIC 48-A shall also be forwarded to the A. M. O., ESI Scheme and the Regional Director.
- (7) The Branch Manager will thereafter enter the particulars in the register as per form given below and sign the certificate on the reverse of the application form.

Sl. No.	Name of IP, Ins. No. and name of spouse	Age	Date of application	Cont. Paid on	Date of issue		Period for which eligible for medical care	Name of dispensary	Remarks
					I. Card/MRE	ESIC 48-A			
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.

- (8) The application forms shall be maintained in the Branch Office in a separate file cover in chronological order giving serial number of entry in the register to each such application.
- (9) The register shall be reviewed periodically and the insured person shall be notified by post at least 15 days in advance that his eligibility to medical benefit shall expire on _____, and that in case he is interested in availing the facility further, he may deposit the contribution for a period of one year. On such further deposit of contribution, his identity card may be revalidated accordingly and all concerned informed.
- (10) Blank forms to be used will be supplied by Regional Office in reasonable quantities to each Branch Office.

(11) The amount of fee collected shall be deposited as usual in ESI Fund A/c No. 1 and included in the statement of A/c No. 1 submitted in form MISLO-05 to the Finance Section of Regional Office.

(12) The Branch Office shall send a monthly statement of the number of persons admitted for medical benefit under this Scheme to the Regional Office. The Regional Office shall maintain a record of the total number of insured persons for the purpose of paying Corporation's share to State Government.

ANNEXURE 'A'
[See Para 12.A.5(1) & (2)]

**Application for medical benefit under Rule 60/Rule 61 of the
ESI (Central) Rules, 1950**

To

The Manager,
Branch Office,
.....

Sir,

*Is/w/o.....Ins.
No.....ceased to be in insurable employment with effect fromwith M/s
..... on account of permanent disablement resulting from employment injury
sustained by me on

*I.....s/w/o.....Ins.
. No.....ceased to be in insurable employment with M/s..... on
my retirement on superannuation with effect from

I am willing to avail of the medical benefit for myself and my spouse from the ESI Dispensary
....., at the scale prescribed by the Corporation/State Govt. for permanently
disabled/superannuated persons. I understand that I and my spouse will be entitled to all reasonable medical
care and treatment except super-speciality medical care and treatment under the ESI Schme. I am also
willing to deposit a sum of Rs. 120/- (Rupees one hundred and twenty only) as contribution @ Rs. 10/- per
month in lump sum for one year in advance, i. e., for the period from to
..... In support of my claim I enclose the following :

- i) Certificate from the employer.
- ii) My declaration in prescribed form.

My present residential address is

Yours faithfully,

Dated:

(L. T. I./Signature of the applicant)

* Strike out which is not applicable

FOR OFFICE USE

(for Rule 60)

The insured person Shri Ins. No.
has been declared permanently disabled on account of the employment injury sustained by him on
..... As per the Regional Office letter no.dated.....he was
examined by the Medical Board/Medical Appeal Tribunal/E. I. Court on and had been
awarded permanent disablement to the extent of% final. The case has been entered in the
Branch Office PDB Register No. on page

(for Rule 61)

The insured person Shri Ins. No.....
has been on the records of this Branch Office and as per the records of the office the IP has been in
insurable employment since The IP has remained insured for 5 years or more on
the date of his superannuation which is

Signature of DA/HC

I have examined the case and the IP is eligible/ineligible for medical benefit. He may be asked to
deposit the contribution/be informed accordingly.

Signature of BRANCH MANAGER

Contribution of Rs. 120/- (Rupees one hundred and twenty only) for a period of one year from
..... to has been deposited by the insured person. The amount has been entered in
A/C no. 1 *vide* receipt no. dated

Signature of HC or BRANCH MANAGER

Certificate in form ESIC 48-A along with MRE has been forwarded to the IMO ESI Dispensary
..... Copies of the same have also been forwarded to the AMO/DMD (ESI). Entry
has been made in the register.

Signature of BRANCH MANAGER

Certificate by Employer

[Under Rule 60 of the ESI (Central) Rules, 1950]

*Certified that Shri Ins. No. employed with us in (Deptt.) as (design.) sustained an employment injury on He was examined by the Medical Board/MAT/E. I. Court on (date). He has ceased to be in insurable employment of our factory/estt. M/s. Code No. with effect fromsolely on account of permanent disability suffered by him. His date of birth as per our records is Had he not become disabled permanently on account of employment injury sustained by him on, he would have continued in our employment till attaining the age of superannuation, i. e., on (date).

[Under Rule 61 of the ESI (Central) Rules, 1950]

*Certified that Shri Ins. No.date of birth an employee of our factory/estt. M/s Code No..... has attained the age of superannuation on He has been superannuated as per factory's/establishment's order no. dated.....(copy enclosed).

He was an insured person under the Act from to
The ESI contributions paid in respect of him for the above period are detailed below.

<u>C. P. ending</u>	<u>No. of days</u>	<u>Amount of cont. paid</u>	<u>Sl. No. in R. C.</u>
---------------------	--------------------	-----------------------------	-------------------------

His contribution for C. P. ending (current C. P.) for days amounting to Rs. is payable/has been already paid.

L. T. I./Signature of I. P.

Signature and seal of the employer
or his agent.

*Strike out which is not applicable

Declaration of the Insured Person
[for medical benefit under Rule 60 of ESI (Central) Rules, 1950]

I Ins. No. ceased to be in insurable employment with effect from on account of permanent disability caused to me due to employment injury sustained by me on I was examined by the Medical Board/Medical Appeal Tribunal/EI Court on and was awarded % disability finally, I was employed with M/s..... in (Deptt.) as (designation). I would have continued in insurable employment but for the permanent disability caused to me due to employment injury.

I solemnly declare and affirm that the particulars given above are true to the best of my knowledge and belief and nothing has been concealed therefrom. If at any time these particulars are found to be false I and my spouse may be disqualified for medical benefit and amount of contribution deposited by me may be forfeited.

T. I/Signature of I. P.

ESIC 48-A.

ANNEXURE 'D'
[See Para 12.A.5 (6)]

The I. M. O. Incharge,
E. S. I. Dispensary,
.....

Subject: Provision of medical benefit under Rule 60/Rule 61 of ESI (Central) Rules, 1950

Sir,

Shri Ins. No after having ceased to be in insurable employment on account of permanent disability due to E. I./attaining the age of superannuation, has applied for availing of medical benefit under the Rules cited on the subject. He has been found to be eligible for medical benefit under these Rules.

He has since paid the specified contribution for the period of one year in advance, i. e., for the period to

He/she and his/her spouse Smt./Shri may kindly be provided medical benefit at the scale provided under the Act (except super-speciality treatment which is not admissible) for a period of one year upto A new M. R. E. showing the period of validation is enclosed.

The I. P. and his/her spouse shall be debarred for medical benefit with effect from, unless the I. P. pays contribution for a further period for which necessary intimation shall be sent, if required.

Yours faithfully,

Encls :- M. R. E.

BRANCH MANAGER

Copy forward to :-

1. A. M. O./DMS (ESI) for information.
2. The R. D. for necessary action.

BRANCH MANAGER

To

Shri.....
Ins. No
.....
(Address)

Subject :- Provision of medical benefit under Rule 60/Rule 61 of the ESI (Central) Rules 1950

Dear Sir,

Please refer to your application in regard to provision of medical benefit to you and your spouse under Rule of the E. S. I. (Central) Rules, 1950.

2. In this connection, it is informed that your case has been carefully examined but it is regretted that you have not been found eligible for medical benefit for the following reasons:

1.
2.

Yours faithfully,

BRANCH MANAGER

B. VOCATIONAL REHABILITATION SCHEME FOR PERMANENTLY DISABLED INSURED PERSONS

Introduction

12.B.1. The ESI Corporation at its meeting held on 24th February, 1994 approved the scheme for vocational rehabilitation of permanently disabled insured persons. This Scheme which was brought into force from 1.11.1994, has been designed to provide financial assistance to the insured persons who are referred to vocational rehabilitation centre for training. Detailed procedure for this Scheme is given below:-

Scope of the Scheme

12.B.2. The vocational rehabilitation scheme framed under the provisions of section 19 of the ESI Act, 1948 has been made applicable for the present to those insured persons in whose case loss of earning capacity resulting from an employment injury has been assessed as not less than 40% as per percentages given in the Second Schedule to the Act for scheduled as well as non-scheduled injuries resulting from an employment injury, i.e., accident arising out of and during the course of employment or from an occupational disease as defined in ESI Act.

Eligibility

12.B.3. An insured person (i) whose permanent loss of earning capacity has been determined as 40% or more (ii) who is in receipt of permanent disablement benefit under the ESI Act, 1948 (iii) who is not in any gainful employment, and (iv) who is not more than 45 years of age on the date of his application, is entitled to avail of the benefits of the vocational rehabilitation scheme.

Procedure for reference

12.B.4. An insured person seeking vocational rehabilitation training will be referred to any of the Vocational Rehabilitation Centres/Institutions run by the Government of India, Ministry of Labour in different States and Union Territories. A list of such institutions is at Annexure 'A'. If any more rehabilitation centres are opened in any area, Regional Office has to send information to Hqrs. so as to consider inclusion of the new centre in the list at Annexure 'A'.

12.B.5. These centres offer vocational rehabilitation training in the field of Radio/T. V. assembly, commercial training (typing/shorthand), metal work, carpentry, cane work and tailoring, etc. Generally, the duration of training will be between 30 to 45 days during which these centres also provide a stipend. These centres also help the persons so trained in securing suitable employment.

12.B.6. The insured person eligible for training under this Scheme has to apply in the prescribed form in duplicate to the Regional Director through the Branch Office at which he is receiving permanent disablement benefit. Specimen of the form is at Annexure 'B'. The Branch Manager will verify all the particulars given in the application and his age from the records available with him and will also satisfy himself personally about the insured person's correct identity. He will also clearly indicate the identification mark of the insured person in the application. He must complete this task within 5 working days of the receipt of the application and forward one copy to the Regional Office for further necessary action.

12.B.7. Regional Office will check the application with reference to PDB file/register maintained in the Regional Office and after obtaining concurrence of Finance Division, enter the particulars of the IP in a register (Specimen at Annexure 'C'). The case will then be referred to the nearest rehabilitation centre where facility for training in the trade chosen by the IP is available, alongwith a standard letter at Annexure 'D'. Original copy of this letter will be sent to the Branch Office which will hand it over to the insured person. Another copy will be sent directly by registered post to the Vocational Rehabilitation Centre

alongwith three copies of the standard reply (Copy at Annexure 'E') to be furnished by the Vocational Rehabilitation Centre certifying that the insured person has undergone the training and the Centre will be requested to hand over the original of this letter to the IP. The Regional Office will also watch effectively the receipt of the confirmation by post from the vocational rehabilitation centre regarding dates and duration of training.

Claim for journey fare and cash allowance

12.B.8. On successful completion of training by the insured person, vocational rehabilitation centre concerned will return to the Regional Director, one copy of the standard letter (Annexure 'E') through the insured person and another copy by post, retaining the third copy with them. The Regional Office will send the attested photocopy of this certificate to the Branch Manager.

12.B.9. The IP will then submit his claim in the prescribed form (Annexure F) in duplicate for conveyance charges/bus/train fare and cash allowance as per his entitlement duly supported by the original certificate at Annexure E to the Branch Manager who will forward the original as well as its copy with his remarks/recommendation to the Regional Office. The Regional Office will authorize payment on the original and return it to Branch Office for payment to the disabled person. Duplicate copy will be retained by the Regional Office for its record.

12.B.10. There will be two categories of such insured persons (i) residing at the same station where the vocational rehabilitation centre/institution is situated and (ii) those residing at other places. The scale of benefits and allowances provided will be as under:

- i) Insured person residing at the same station where the Vocational Rehabilitation Centre/institution is also situated will be provided conveyance charges at the same rate as are admissible to a disabled insured person who goes to the artificial limb centre for fixation, repair, replacement, etc. of the artificial limb. Besides, cash allowance equal to expenditure charged by the said centre/institution or Rs. 123/- per day whichever is more will be paid to him for all the days of his stay for training at the vocational rehabilitation centre/institution.
- ii) Insured person residing at other places will be paid second class railway/bus fare for the journey undertaken by him from his normal residence to the Vocational Rehabilitation Centre/Institution and back to his residence by mail/express train or ordinary class in bus. He will also be paid cash allowance equal to the expenditure charged by the said centre/institution or Rs. 123/- per day whichever is more for all the days of his stay for training at the Vocational Rehabilitation Centre/Institution. The journey fare will also be paid to an attendant subject to the condition that the need for an attendant will have to be certified by an authority to be specified by the Director General.

IP to follow instructions at VRC

12.B.11. The insured person undergoing vocational training shall observe conditions and follow instructions prescribed by the concerned vocational rehabilitation centre for the purpose of satisfactory completion of his training.

Payment at Branch Office

12.B.12. Payments made under this Scheme will be entered in red ink under signatures of the Branch Manager in the PDB sheet of the insured person and duplicate copy of the claim will be sent to Regional Office for record.

12.B.13. The payments will be shown in the schedule sheet under the head "C-other-benefits-expenditure on vocational rehabilitation of disabled persons".

Addresses of vocational rehabilitation centres for the handicapped

1. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
22/1 Hosur Road,
BANGALORE – 560 029,
2. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
38, Badan Roy Lane, Beliaghata,
KOLKATA– 10.
3. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
A. T. I. Campus,
Vidhya Nagar,
HYDERABAD – 500 007.
4. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
C. T. I. Campus, Guindy,
CHENNAI – 600 032.
5. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
Rehabari,
GUWAHATI – 781 008.
6. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
Nalanchira,
THIRUVANANTHAPURAM – 15.
7. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
S. I. R. D. Campus, Unit VIII,
BHUBANESWHAR – 751 012.
8. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
North Banamalipur Road,
AGARTALA – 709 001.
9. Superintendent,
Vocational Rehabilitation Centre for Handicapped,
A. T. I. Campus, Gil Road,
LUDHIANA.
10. Superintendent,
Vocational Rehabilitation Centre,
Corporation New Market,
Near Bus Stand, Napier Town,
JABALPUR.
11. Superintendent,
Vocational Rehabilitation Centre,
I. T. I. Campus, Kuder Nagar,
AHEMDABAD – 382 340.
12. Superintendent,
Vocational Rehabilitation Centre,
A. T. I Campus, B. N. Purab Road,
Chuna Bhatti Road, Sion,
MUMBAI – 400 022.
13. Superintendent,
Vocational Rehabilitation Centre,
G. T. I. Campus, Udyog Nagar,
Near Govind Nagar,
KANPUR – 208 002.
14. Superintendent,
Vocational Rehabilitation Centre,
Mahavir Industrial Estate,
Bahucharaji Road, Kareli Bagh,
VADODARA – 390 018.
15. Superintendent,
Vocational Rehabilitation Centre,
A-84, Gandhi Vihar,
Police Colony Anisabad,
PATNA – 800 002.
16. Superintendent,
Vocational Rehabilitation Centre,
I. T. I. Campus, Pusa,
NEW DELHI – 110 012.
17. Superintendent,
Vocational Rehabilitation Centre,
4-S-23, Jawahar Nagar,
JAIPUR – 302 004.

APPLICATION

The Regional Director,
ESI Corporation,
Regional Office,
.....

Through
Manager, Branch Office,
.....

Subject :- Application for vocational rehabilitation under the Scheme of vocational rehabilitation training of permanently disabled insured persons under the ESI Act, 1948.

Sir,

I am herewith submitting my application for referring my case to Vocational Rehabilitation Centre and for receiving the cash financial assistance.

1. Name of IP :
2. Father's/Husband's Name :
3. Ins. No. :
4. Name of Branch Office from where PDB is being drawn :
5. Residential address :
6. Date of employment injury :
7. Location of employment injury and nature of disability :
8. Percentage loss of earning capacity :
9. Date of commencement of permanent disablement benefit :
10. Particulars of present employment, if any :

11. (a) Are you employed anywhere :
- (b) Present wages :
- (c) If currently not employed, name & address of the employer, with whom you were last employed. :
- (d) Date upto which employed :

DECLARATION BY THE APPLICANT INSURED PERSON

I hereby declare as follows:-

- (i) The particulars given above are true and correct to the best of my knowledge and belief and nothing has been concealed.
- (ii) I will abide by terms and conditions of the Vocational Rehabilitation Training Scheme promulgated under ESI Act and the rules and regulations of the Vocational Rehabilitation Centre.
- (iii) No liability, what-so-ever, will lie with the ESI Corporation except that admissible under the above Scheme.
- (iv) I also understand that in case of any false statement or concealment of information, I will be liable to legal action under the ESI Act and also liable to refund any amount received by me, to the ESI Corporation.
- (v) I undertake to produce the training completion certificate from the vocational rehabilitation centre concerned.

Dated: (SIGNATURE OF APPLICANT)

Certified that the above declaration is correct to the best of my knowledge and belief.

Dated: Signature
 Designation
 Rubber Stamp

N. B.: This form may be got attested from any of the following authorities:

- i) An officer of revenue, judicial or magisterial department of government or a municipal commissioner or Workmen’s Compensation Commissioner or the head of gram panchayat under the official seal of the panchayat or
- ii) A Member of Parliament or
- iii) A Member of Legislative Assembly or

- iv) A Member of Standing Committee or of the Employees' State Insurance Corporation or
- v) A Member of Regional Board or Local Committee of the Corporation.

PARTICULARS TO BE FILLED IN BY THE BRANCH OFFICE

- i) Date of receipt of application at Branch Office
- ii) Identification marks of insured person as verified by Branch Manager
- iii) Name, address and code no. of the employer with whom the applicant insured person was last employed and date upto which he was employed as verified by the Branch Manager
- iv) Certified that all the information furnished by this insured person has been verified and the particulars regarding the age, employment position, percentage of permanent disability have been verified and it is found that the insured person is entitled to cash benefits under the Scheme.

Signature of Branch Manager with seal

Dated:

Date of dispatch to Regional Director.....

Branch Office:

REGISTER OF INSURED PERSONS REFERRED TO THE VOCATIONAL REHABILITATION CENTRES FOR VOCATIONAL TRAINING

S. No.	Particulars of IP		Name of Branch Office paying PDB	Particulars of Disability		Date of receipt of application		Date of reference by RO to VRC	Name of VRC	Date of receipt of acceptance letter from VRC
	Name & Ins. No.	Age on the date of application		Date of EI and location	% of permanent disability finally assessed and daily rate of PDB	at Branch Office	at Regional Office			
1	2	3	4	5	6	7	8	9	10	11
Date of communication to insured person for undergoing training	Period of training	Nature of trade in which training imparted	Date of submission of claim by IP at BO	Rate of cash allowance	Amount of allowance paid/no. of days for which payment made	Amount of conveyance charges reimbursed	Total amount paid to the IP	Dated initials of DA/HC/ Superintendent/ B. O.	Remarks	
12	13	14	15	16	17	18	19	20	21	

ORIGINAL: by hand to trainee insured person
DUPLICATE: by registered post to VRC
TRIPLICATE: file

From:

Regional Director,
Regional Office,
ESI Corporation,
.....

To

The Superintendent/Officer Incharge,
Vocational Rehabilitation Centre,
.....,
.....

Sub: - Vocational Rehabilitation Training to Shri
ESI Ins. No.....

Sir,

As you may be aware, the ESI Corporation provides medical care and cash benefits to insured persons in the contingency of sickness, maternity, disablement and death due to employment injury. In the case of permanent total or partial disablement, the Corporation provides permanent disablement benefit in the form of periodical payments. However, some of these insured persons who are in receipt of such benefits from the Corporation are not able to undertake any gainful economic activity because of their disability.

We understand that your Vocational Rehabilitation Centre provides training to such disabled persons to enable them undertake gainful activity and secure alternative employment. We are, therefore, referring the person with undermentioned particulars:

Shri, S/o Sh.....
..... Ins. No to your
centre with the request that he may be examined and imparted vocational rehabilitation training at your Centre in a suitable trade. In case, he is found suitable for imparting training by you, this office may kindly be informed per return of post the trade for which he has been selected, the duration of the training and the date from which he is required to report at your Centre for the said training.

After completion of the training of Shri at your centre, you are also requested kindly to return the enclosed letter in original, duly filled in, through the trainee and its duplicate to this office by registered post under your rubber stamp for our records.

Encl. as above in triplicate

Yours sincerely,

(NAME AND DESIGNATION)

ORIGINAL : by hand
DUPLICATE : by registered post
TRIPLICATE : file

From

.....
.....

To

The Regional Director,
ESI Corporation,
.....
.....

Sub:- vocational rehabilitation training of Shri

Sir,

I am to refer to your letter no. dated, referring Shri
..... s/o Sh. for vocational rehabilitation training at this Centre.

Shri has undergone the training at this centre from
..... to (dates) in the trade and has completed
the same satisfactorily. He has attended the training on all working days except for
(dates). No amount/An amount of Rs has been charged for the expenditure towards this
training.

Yours sincerely,

(SUPERINTENDENT)
VOCATIONAL REHABILITATION CENTRE

SEAL:

Name:

Ins. No.:

To

The Manager,
Branch Office,
ESI Corporation,
.....

Sub: - Claim for conveyance allowance/bus or train fare/cash assistance.

Sir,

With reference to Regional Director..... letter no..... dated..... referring me to Vocational Rehabilitation Centre at for undergoing vocational training, I submit the certificate of completion of my training for the period from to except and accordingly I claim conveyance charges/bus/train fare for self only/ and for the attendant (strike out whichever is not applicable) and cash allowance as per particulars given hereunder.

Yours faithfully,

Date:

Signature:

Name:

Insurance No.

CERTIFICATE

To be filled in by Medical Referee in case an attendant was required to accompany the insured person.

Certified that Shri s/o Ins. No. is/was unable to travel by ordinary means of conveyance alone and his physical condition warrants/warranted the presence of an attendant to escort him to the Vocational Rehabilitation Centre.

MEDICAL REFEREE

SEAL

C. CONFINEMENT EXPENSES FOR IW/IP'S WIFE

12.C.1 The Central Government, by an amendment to the ESI (Central) Rules, 1950, introduced Rule 56 A w.e.f. 16.11.1996. The new Rule provided for payment to an IW or to an IP in respect of his wife, a sum of rupees two hundred and fifty per case as medical bonus on account of confinement expenses. The condition for the payment was that the confinement should have occurred at a place where necessary medical facilities under the ESI Scheme were not available. This rule was amended w.e.f. 24.01.2004 to read as under:-

56A – Confinement Expenses – An insured woman and an insured person in respect of his wife shall be paid a sum of rupees one thousand as confinement charges.

Provided that the confinement occurs at a place where medical facilities under the Employees' State Insurance Scheme are not available.

Provided further that the confinement expenses shall be paid for two confinements only.

The term 'medical bonus' was replaced by the term 'confinement expenses'.

12.C.2. With effect from 01.12.2008 the amount of confinement expenses has been raised to Rs. 2500/- per confinement

12.C.3. The following instructions are laid down in this respect:

- 1) Confinement expenses are payable in lieu of confinement charges which were being paid before insertion of Rule 56A.
- 2) Confinement expenses will be paid for not more than two confinements.
- 3) Confinement expenses are payable for confinements occurring at a place where necessary medical facilities under the ESI Scheme/institutions are not available.
- 4) Payments made as confinements expenses will be treated not as cash benefits but as part of medical benefit shareable in the usual ratio between the Corporation and the State Government.

12.C.4. Payment procedure shall as under:

- 1) The claim for confinement expenses shall be submitted by IW/IP in respect of his wife at the Branch Office to which she/he is attached, in the form at Annexure.
- 2) Where the Branch Manager has any doubts about the non-availability of confinement facilities under the ESI Scheme at a particular center, he should make inquiries (e.g. by reference to all-India list of ESI institutions, a copy of which is supplied to each Branch Office, checking the declaration form wherein permanent address is usually recorded, or by inquiries from the employer and the IPs whose native place is near about the area in which confinement took place.
- 3) If the claim is found admissible, an entry will be made in red ink in the middle column of the ledger sheet under the heading 'Additional information' and duly attested by the Manager. The benefit payment docket will indicate 'Confinement expenses' which will be attached to his claim.

12.C.5. Accounting procedures of the expenses shall be as follows:

- 1) The expenditures incurred shall be shown in a separate column of the schedule sheet with suitable remarks as 'Confinement expenses'. In the Finance Branch of Regional Office, it will be booked under the head "Medical treatment and care and maternity facilities (expenses incurred by the Corporation)."
- 2) At the close of the financial year, the Regional Director shall intimate the total expenditure incurred, under the aforesaid head of account duly verified by the Finance Branch of Regional Office, during the year to Hqrs. Office (Medical Division) so that necessary action for adjustment of State's share (1/8th) is taken by Hqrs.

Form for claiming Confinement Expenses under Rule 56A

To

The Manager,
Branch office,

Dear Sir,

I _____ wife/son of _____, Ins.no. _____
hereby state that I/my wife gave birth to a _____ child on _____ at
_____. District _____, in State of _____.

- I declare that no medical facilities under the ESI Scheme exist at the place of my child's birth.
- I further declare that I have claimed confinement expenses for no/ one other child.
- I also declare that my husband/wife has not preferred a claim for confinement expenses from any other source.
- I hereby claim confinement expenses of Rs. 2500/- (Rupees two thousand five hundred only).

Signature/Thumb Impression of Insured woman/Insured person

D. ARTIFICIAL LIMBS FOR AMPUTEE IPS AND FAMILY MEMBERS

Background information

12.D.1. In early stages of implementation of the ESI Scheme, artificial limbs were being provided only to the insured persons by the Corporation itself and all arrangements for sending amputee IPs to an approved Artificial Limb Centre (ALC), providing an escort, their stay and training at the Centre, payment of incidental charges during their transit and their stay at the Centre and their return etc. were being made by the concerned Regional Offices and the entire cost was being borne by the Corporation.

12.D.2. The Corporation in its Resolution dated 24.2.1978 resolved to enlarge the scale of medical benefit so as to provide artificial limbs, appliances and aids to insured persons as well as their families as part of medical care under the ESI Scheme. A list of items to be provided can be seen at Annexure 'A' for the general information of the Branch Manager so that in time of need and doubt by IP or the IMO, he may be able to enlighten/guide them.

State Govt. to arrange supply

12.D.3. State Governments were informed by the Hqrs. in clear terms that (i) provision of items like artificial limbs, appliances and aids (full list at Annexure 'A') should be deemed as part of medical care, (ii) State Government should make arrangements with the institution concerned for payment of charges direct to that institution for artificial limbs, appliances, etc supplied to ESI beneficiaries, (iii) the State Government was fully empowered to spend money on these items as part of shareable expenditure on medical care and sanction of the Corporation was not required.

12.D.4. Thus, arrangements for sending IPs and their family* members to the ALC, payment of railway/bus fare for to-and-fro journeys between IP's residence and ALC, payment of incidental charges for stay in the ALC and payment of charges and cost of the limbs direct to that institution for its services are to be made by the AMO, ESI Scheme.

Role of the Branch Office

12.D.5. Every amputee IP or other beneficiary who may have lost a limb should be encouraged to get an artificial limb fitted at the cost of the ESI Scheme. The IMO may not be generally aware of the procedure and facilities to be provided to beneficiaries sent to ALC for fitting an artificial limb. So, either the IMO or the IP may himself approach the BM for information, guidance and suggestions in this regard. Rather, it is quite possible that the BM may have to take all the initiative to get an amputee referred to the ALC.

Procedure for guidance of IMOs

12.D.6. Hqrs. Office of ESIC had sent to every State Government a copy of the procedure being followed by the Corporation for adoption mutatis-mutandis by the State Government. Broad outlines of the same may be seen in Annexure 'B' which has been provided so that the BM may be able to guide/inform the treating IMO and, where necessary, the Office of the AMO also as to the procedure to be followed and the expenditure to be incurred on provision of artificial limbs to IPs and their family members.

* As defined in the ESI Act, as amended, vide clause (ii) of section 2 thereof.

Procedure for payment of rehabilitation allowance by ESIC

12.D.7. In addition to the aforesaid shareable expenditure, the Corporation has, by its Resolution dated 22.12.1979, agreed to pay rehabilitation allowance in cash to every insured person for each day on which he remains admitted in Artificial Limb Centre (ALC) for fixation or repair or replacement of his artificial limb. This payment is subject to the following conditions:-

- (i) It is payable from the date of his admission into the ALC upto the date of his discharge.
- (ii) The rate of payment was equal to the standard benefit rate upto 15.11.96 whereafter it was raised to double the standard benefit rate.
- (iii) No waiting period will be deducted and the number of days for which rehabilitation allowance is paid will not count against the duration of ordinary sickness benefit.
- (iv) Those who are not eligible to sickness benefit will be paid rehabilitation allowance as follows:-
 - (a) Where the insured person is not eligible to sickness benefit during the period of stay at Artificial Limb Centre, the allowance may be paid at twice the standard benefit rate last payable or applicable as per records of Branch Office/Regional Office.
 - (b) In case the period of stay of the insured person in the ALC is before the start of the first benefit period of the insured person, the daily rate of rehabilitation allowance shall be calculated in the same manner as the daily rate of temporary disablement benefit is calculated in respect of an insured person who sustained employment injury before the start of the first benefit period in respect of him, subject to the condition that the daily rate of rehabilitation allowance shall be double the standard benefit rate so calculated.

12.D.8. The Branch Manager may pay this benefit on application and claim submitted by the IP duly supported by a certificate from the ALC about the days of the IP's stay in the said Centre.

12.D.9. The expenditure on payment of rehabilitation allowance shall be booked under the Head: "C-other Benefits – (A) Expenditure on rehabilitation of disabled persons."

**List of artificial limbs, aids and appliances included as part of
medical care admissible to IPs and family members**

1. Artificial limbs.
2. Hearing aids.
3. Spectacles (frame costing not more than Rs. 100/- and replacement of frames not to be made earlier than 5 years). To insured persons only
4. Artificial dentures, teeth. -do-
5. Artificial eye.
6. Wigs (replacement not earlier than 5 years) To female beneficiaries only
7. Cardiac pacemaker.
8. Wheel chair/tricycle.
9. Spinal supports (jackets, braces etc.)
10. Cervical collars.
11. Walking callipers, surgical boots etc.
12. Crutches.
13. Hip prosthesis, total hip.
14. Intra-ocular lenses
15. Any other aid or appliances prescribed by the specialist as part of treatment costing not more than Rs. 2,000/-.

Facilities named below have also been included as part of medical care

16. Cardio-thoracic surgery.
17. Renal dialysis.
18. Kidney transplant

**Broad outline of the procedure to be followed in respect
of cases referred to Artificial Limb Centre**

1. The State Government recognises institutions to which amputees may be referred for fitting an artificial limb and circulates it to all Centres in the State where ESI Scheme is in force. It may have to enter into an arrangement for payment of charges direct to these institutions so that IP/beneficiary has not to be burdened with payment of charges and then seeking reimbursement thereof from the AMO.
2. To be eligible for fitting/repair/replacement of artificial limb, IP should have lost his limb as a result of employment injury, or if he lost the limb as a result of non-employment injury or in case his family member needs it, he should be an insured person as defined in the ESI Act.
3. Full particulars of the amputee in medical/surgical terminology in respect of the amputee will be provided to the concerned institution by the AMO with a request to intimate the date and time when the amputee can be sent.
4. On receipt of intimation, the amputee will be informed and paid an advance to help him meet his incidental expenses for his transit and stay in the ALC according to the scale approved by the State Government.
5. Amputee will be entitled to second class railway/bus fare and conveyance charges from his residence to the railway station and *vice versa* both ways. In case an escort is needed, only his railway/bus fare will also be paid.
6. Amputee will report to the ALC where he will get the artificial limb fitted and also receive training for its use.
7. On completion of training, he will report back to the IMO who may be of great help in motivating the amputee to make full use of the artificial limb so that he can again become as useful to his social environment as he used to be before losing the limb.
8. The ALC will raise a bill against the AMO for payment direct to that institution. However, if the IP has incurred the charges, he may be guided to submit a bill for reimbursement which should be processed without delay.
9. If the beneficiary is the IP himself, he should be directed to report to Branch Office concerned for receiving rehabilitation allowance for the days of his stay at the artificial limb centre.

E. UNEMPLOYMENT ALLOWANCE UNDER RAJIV GANDHI SHRAMIK KALYAN YOJANA-PROCEDURE*

Introduction

- (1) Section 19 of the ESI Act provides that the Corporation may, in addition to the scheme of benefits specified in this Act, promote measures for improvement of the health and welfare of Insured Persons and for rehabilitation and re-employment of Insured Persons who have been disabled or injured and may incur in respect of such measures expenditure from the funds of the Corporation within such limits as may be prescribed by the Central Government.
- (2) In addition to the Scheme of Benefits specified in the Act, the Corporation has decided to provide Unemployment Allowance to the IPs who have been rendered unemployed involuntarily due to closure of the factory/estt., retrenchment or permanent invalidity arising out of non-employment injury. The scheme has been named as “Rajiv Gandhi Shramik Kalyan Yojana” and it came into force w.e.f. 1.4.2005. It applies to insured persons who become unemployed on after the said date.
- (3) IPs and their families will also be entitled for medical care from ESI dispensaries/ hospitals for such periods, the unemployment allowance is payable in the first spell.

Kinds of Unemployment covered under the Scheme

12.E.1 Unemployment which arises due to following reasons shall be covered under the Scheme:-

- a) Retrenchment as defined in the Industrial Disputes Act, 1947.
- b) Closure of the factory/ establishment as defined in the Industrial Disputes Act, 1947.
- c) Permanent invalidity not less than 40% arising out of non-employment injury. The invalidity should be duly certified by a Medical Board constituted by the Central or State Government.

Eligibility Conditions

12.E.2

- a) The applicant should have been an Insured Person under the ESI Act on the date of loss of insurable employment on account of retrenchment, closure of the factory/ establishment of permanent invalidity arising out of non-employment injury, as defined above.
- b) Contribution in respect of him/her should have been paid/payable for a minimum period of three years prior to the loss of employment. The duration of a year in this context, would mean a period of 156 days or more. An IP who has lost employment and in respect of whom the contribution was paid/payable for 156 days or more in any two consecutive contribution periods in this reckoning will be deemed as having worked for one full year. Similarly, those who have paid contribution for 78 days or more in a contribution period will be deemed as having served for a half year.
- c) The period of service of an I.P. need not be continuous with one employer. The I.P. shall be entitled to this allowance irrespective of that fact whether part of his/her service as employee was rendered in the insurable employment with any other employer in the same or in any other region.
- d) The IP need not satisfy any qualifying conditions afresh for claiming unemployment allowance for any subsequent spells provided to him/her but he/she should be an IP on the subsequent date of unemployment. The unemployment allowance in the subsequent spells shall be at the same rate as has already been decided /paid.

*Vide Hqrs. Circular No. N-11/12/2003-Bft.Vol.II dated February 9, 2009, the procedure given on these pages stands substituted by a simplified scheme which appears verbatim at the end of the procedure detailed herein.

- e) As specified in Section 65 of the Act, an IP shall not be entitled to any other cash benefit and the Unemployment Allowance simultaneously for the same period. However, he/she may opt for either of the two, i.e., cash benefit or unemployment allowance. The term 'cash benefit' excludes periodical payments of PDB under ESI Act and Regulations.
- f) As specified under Section 61 of the ESI Act, an IP who is in receipt of unemployment allowance shall not be entitled to receive any similar benefit admissible under the provisions of any other enactment.
- g) There will be one month waiting period after the retrenchment

Disqualification/termination of unemployment allowance.

12.E.3 Unemployment allowance shall not be admissible in the following circumstance:

1. During lock out.
2. Lay off/temporary closure of factory/estt.
3. Strike resorted to by the employees.
4. Voluntary abandonment of employment/ voluntary retirement/ premature retirement.
5. Less than three years contributory service as defined vide Para 12.E.2 (b).
6. On attaining the age of superannuation or 60 (sixty) years whichever is earlier.
7. Convicted (i.e. punished for false statement) under the provisions of Section 84 of the ESI Act read with Rule 62 of the ESI (Central) Rule
8. On being re-employed elsewhere during the period he/she is in receipt of unemployment allowance.
9. Dismissal/termination under disciplinary action.
10. On death of IP.

Rate of Unemployment Allowance

12.E.4 The rate of Unemployment Allowance in respect of a person who becomes unemployed as defined in Para 12.E.1 shall be calculated on the basis of average daily wage during the last four completed contribution periods, immediately preceding the date of unemployment. The daily rate of unemployment allowance shall be the Standard Benefit Rate as specified in the Table of Standard Benefit under Rule 54 of ESI (Central) Rules 1950 corresponding to the average daily wage so arrived. The following illustrations will make the position clear:-

- a) Date of Unemployment : 01/04/2005
- b) Contributory particulars of the preceding four contribution periods:

Period	No. of Days	Wages
Oct.'04 to March'05	86	8,525-00
April '04 to Sept.'04	67	6,507-00
Oct.'03 to March'04	114	9,608-00
April'03 to Sept.'03	47	3,870-00
Total	314	28,510-00

$$\text{Average Daily Wages } \frac{28,510}{314} \times \frac{115}{100} = 104.41$$

Standard Benefit Rate: Rs.53-00 per day

The rate of Unemployment Allowance shall be @ Rs.53-00 per day.

Duration of allowance

12.E.5 The maximum duration, for which an IP shall be eligible to draw the unemployment allowance during his/her entire life time, would be **twelve months**. However, the unemployment allowance shall not be admissible for a period less than one month at a time. In case the beneficiary gets gainful employment subsequently, he/she can avail the balance allowance in case the contingency so arises but he/she should again be an IP to be eligible for unemployment allowance for subsequent spells.

Medical care.

12.E.6 (1) The IP eligible for unemployment allowance under the Scheme shall also be entitled to medical care for himself/herself and his/her family from the ESI Dispensaries/ ESI Hospitals/IMP Clinics for a period of 12 months from the date of unemployment or till the end of benefit period corresponding to contribution period before unemployment, whichever is later.

(2) In the event of death of the IP on any date prior to the expiry of 12 months period of unemployment allowance, the family of the deceased IP shall continue to be entitled to medical care for 12 months as the case would have been, had the IP remained alive.

(3) Medical care under this scheme shall, however, be restricted to only for the first spell of unemployment.

Submission of claim for Unemployment Allowance

12.E.7 The claim for Unemployment Allowance shall be submitted by the claimant at any time but not later than six months from the date of retrenchment/ unemployment to the appropriate Branch Office in prescribed Form (UA-1) supported by the documentary evidence (in Form UA-2) proving his/her retrenchment/ unemployment/ invalidity. This certificate is to be issued by Inspector of factories, Assistant/Deputy Labour Commissioner, Workmen's Compensation Commissioner or any other authority specified in this regard. Certificate of invalidity will be issued by the medical board constituted by the Central/State Govt.

9 months for those who rendered jobless on or after 01.07.2010 (vide circular No. N-11/12/2003-Bft.II dated 26.07.2010)

Procedure to be adopted by Branch Office for settlement of claims of Unemployment Allowance.

12.E.8.1 On receipt of claim in writing on a prescribed Form (UA-1) from the unemployed IP, the Branch Manager of Branch Office shall verify the facts of unemployment mentioned therein. He/ she shall also ascertain three years contributory service condition from record available with the Branch Office or will seek the details from the last employer in Form (UA4-1) or from previous employer(s) in Form (UA4-II) by sending a letter in Form (UA-3) to the employer(s). Thereafter, he will furnish the information in prescribed Form (UA-5) in this regard and forward the same to Regional Office/Sub-Regional Office/Divisional Office immediately so as to ensure that entire process is completed within one month.

12.E.8.2 In respect of each of the contribution periods expiring before the relevant date i.e. the date of unemployment, eligibility to unemployment allowance has to be determined from the relevant return of contributions available with the Branch Office. If any of these returns is not available, ESIC-71 may be issued. But it is incumbent upon the Branch Manager to get the particulars of each ESIC-71 verified with reference to original records of the employer by the Branch Office official not below the rank of an Upper Division Clerk and a certificate of verification of employer's records will be duly recorded in the relevant register and where the concerned employer is in partial or total default with regard to submission of return of contribution, this fact should be clearly recorded in "remarks" column (S. No.11) of the unemployment allowance register.

12.E.8.3 The Branch Office will furnish information in prescribed form (UA-5) to Regional Office/ Sub-Regional Office/ Divisional Office where the case will be examined thoroughly and after ascertaining all the facts, the Regional Office/ Sub-Regional Office/ Divisional Office will communicate its decision to the IP and the Branch Manager not later than one month from the date of receipt of claim from retrenched/ unemployed IP (in Form UA-7).

12.E.8.4 The payment of unemployment allowance will be made on periodic monthly basis on receipt of claim form in form UA-9. For this purpose 'month' means a period of 30 days.

12.E.8.5 On receipt of sanction from Regional Office/ Sub-Regional Office/Divisional Office, the Branch Manager shall simultaneously communicate in the prescribed form (UA-8) to the concerned IMO Incharge to provide medical facilities to IP and his/her family.

Mode of payment.

12. E.9 The unemployment allowance shall be paid/ payable by Branch Office to IPs by Account payee cheque only. In the event of death of IP, the amount of unemployment allowance shall be paid/payable upto and including the date of death of IP, to his/her nominee/legal heir as prescribed under Para(s) P.3.79.1 to P.3.81 of the Branch Office Manual.

Maintenance of records and registers at Branch Office.

12. E.10 Register as per prescribed proforma in Form UA-6 shall be maintained by the Branch Office.

Preparation of payment docket and schedule sheet.

12. E.11 (i) The payment of unemployment allowance shall be passed only by Branch Manager and the payment will be booked under the head "Other Benefits" with a distinct sub-head "Unemployment Allowance" which should be reflected separately in Form ESIC-19, as well as in A-19, and monthly summary.

(ii) Corresponding entries should be made in ledger sheet in red ink. A remark will also be made on Declaration Form of the IP.

12.E.12 HQRS. Circular No. N-11/12/2003-Bft. II/ Vol.II dated 9th February,2009 (see after form UA9)

EMPLOYEES' STATE INSURANCE CORPORATION
CLAIM FOR UNEMPLOYMENT ALLOWANCE

I _____ s/w/d of Sh. _____
Insurance No. _____ have been declared unemployed due to closure of the Factory/ Estt.,
retrenchment, permanent invalidity resulting from non-employment injury, as per the Certificate in form UA-2
attached. I claim Unemployment Allowance accordingly for the period from _____ to _____.

I declare that I have contributed under the provisions of the ESI Act for the periods as per details overleaf.

The amount due may be paid to me by cheque at the Branch Office.

I also declare that:-

1. I have not taken up any gainful employment during the above period.
2. I am not in receipt of any other similar benefit admissible under the provisions of any other enactment.
3. I have not attained the age of superannuation or of 60 (sixty) years during the period of claim.
4. I have not been convicted u/s 84 of ESI Act.
5. I have not been rendered unemployed due to voluntary abandonment of employment, voluntary retirement, pre-mature retirement etc.
6. I have not been dismissed/ terminated under disciplinary action.
7. I have not challenged the closure/ retrenchment in any court of law.
8. I hereby undertake to repay the whole amount forthwith on demand by the ESIC, if it is discovered at any time that I was not lawfully entitled to that amount.

Dated:

**Signature or Thumb Impression
Of the Claimant**

Encl: UA-2

Permanent Address _____

Name, Address & Code No. of Factory/ Estt

Important:-

Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend to six months or with a fine upto Rs.2,000/- or with both.

PTO

DETAILS OF PAST EMPLOYMENT

Sl. No.	Name & Address of the Factory/ Establishment	Code No.	Token No./ Distinctive No., if any	Period		Remarks
				From	To	

Date:

Signature/Thumb Impression

Place:

Ins. No. _____

Address _____

**Certificate of unemployment due to retrenchment/closure of factory/permanent
invalidity arising out of non-employment injury to the extent of 40% or more.**

Certified that Shri/Smt./Kumari _____ s/w/d of Sh. _____
_____ employed with M/s. _____ has lost
his/her employment w.e.f. _____ due to the following reasons.

1. Permanent closure of the factory

2. Retrenchment

3. Permanent invalidity arising out of non-employment injury to the extent of 40% or more.

Place: _____

Signature _____

Dated: _____

Name _____

Seal & Stamp of the signing authority

N.B. This certificate is to be issued by Inspector of Factories/ Assistant/ Dy. Labour Commissioner/ Workmen's Compensation Commissioner or any other authority specified in this regard.

BRANCH OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

No.

Dated:

M/s. _____

Subject: Certificate of Retrenchment/ Closure of Factory/ Permanent invalidity arising out of non-employment injury & continuous service in respect of Shri/Smt./Km. _____ Ins. No. _____ for grant of Unemployment Allowance.

Dear Sir,

It is informed that the above-named insured person has preferred a claim for Unemployment Allowance to this office. With a view to determine his/her entitlement to Unemployment Allowance under ESI Act, it is necessary to know the period/ position of his/her employment in your factory/estt. as an 'employee' under the ESI Act, as mentioned in the subject.

I am, therefore, to request you to fill up the enclosed format/ certificate and forward it to this office within 7 days for further necessary action.

Yours faithfully,

Encl: Form UA4-I/UA4-II

BRANCH MANAGER

To

The Manager,
Branch Office _____,
Employees' State Insurance Corporation,
_____.

**Report in respect of Insured Person declared unemployed due to closure of the factory/
establishment/ retrenchment/permanent invalidity due to non-employment injury.**

Name, Code No. & Address of the Factory/ Estt. _____

Particulars of the I.P.

- 1) Name _____ (2) Sex _____ (3) Ins. No. _____
- 4) DOB _____ (4a) Date of Superannuation _____
- 5) Father's/ Husband Name _____
- 6) Date of appointment _____
- 7) Date of retrenchment/unemployment/permanent invalidity _____
- 8) Reason of unemployment _____ (copy of order to be attached).
- 9) Details of contributory particulars for the period of employment with us are as under:-

Sl. No.	Contribution Period (s)	No. of Days	Amount of Wages	Sl. No. of R.C.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Certified that the above IP/ employee of our factory/estt./, has been retrenched/ declared unemployed due to closure of the factory/ estt. or being permanently rendered invalid due to non-employment injury.

The above particulars are correct to the best of my knowledge and belief.

Signature _____
Designation _____
Rubber Stamp _____

CERTIFICATE OF EMPLOYMENT-CUM-PAYMENT OF CONTRIBUTION

Certified that Sh./ Smt./ Kumari _____ S/W/d of Sh.
_____ Insurance No. _____ was employed with us from
_____ to _____ in the Department _____.

His/ her contributory particulars for the above period are as under:-

Sl. No.	Contribution Period	No. of Days	Amount of Wages	Sl. No. of R.C.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Signature _____
Designation _____
Rubber Stamp _____

To,

Branch Manager,
ESI Corporation,
_____.

BRANCH OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

1. Insurance Number of I.P. _____
2. Name of insured person _____
3. Father's / husband's name _____
4. Permanent address _____

5. Name, code No. & address of the employer _____

6. Date of appointment _____ 6. A. Date of Superannuation _____
7. Date of Retrenchment/ Closure of Unit/ _____
Permanent invalidity arising out of non employment injury etc.
8. Details of Contributory particulars:-

Sl. No.	Contribution Period (s)	No. of days	Amount of Wages	Sl.No. of R.C./CCP/ESIC - 71 Register	Code No. of the Employer
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

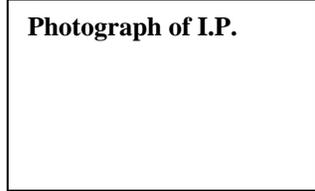
9. Whether employer's certificate is enclosed YES/NO
10. Whether the I.P. is in receipt of any other similar Benefit YES/NO
11. Whether eligible for Unemployment Allowance YES/NO
12. Average Daily Wage:

$$\left. \begin{array}{l} \text{Total wages paid during the} \\ \text{Preceding four Cont. Periods} \\ \hline \text{Total No. of Days} \end{array} \right\} \text{_____} \times \frac{115}{100} = \text{Rs. _____}$$

13. Standard Benefit Rate : Rs. _____
14. Daily Rate of Unemployment Allowance: (Rs. _____) (Rs. _____)

Signature of D.A. Signature of Checker Signature of Br. Manager

BRANCH OFFICE _____



EMPLOYEES' STATE INSURANCE CORPORATION
UNEMPLOYMENT ALLOWANCE REGISTER

Name of I.P./I.W.	Father's/ Husband's Name	Insurance No.	Name, Code No. & Address of Factory/ Estt. last employed
(1)	(2)	(3)	(4)

Date of Unemployment due to Retrenchment/ Closure of Factory/ Permanent invalidity	Basis of Calculation i.e. RC/CCP/ESIC 71	Date of Verification	Date of Reference to Regional Office	Date of Decision of Regional Office	Daily Rate of Unemployment Allowance	Remarks
(5)	(6)	(7)	(8)	(9)	(10)	(11)

Date of Claim	Period of Claim	Rate	Amount	Prep. By	Checked by	Initial of BM	S.S. No. & Date	Cheque No
(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)

REGIONAL OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

No.

Dated:

To,

Shri/Smt./Km. _____

Subject: Provision of Unemployment Allowance U/s 19 of ESI Act, 1948.

Dear Sir/Madam

Please refer to your claim in regard to provision of Unemployment Allowance to you under Section 19 of the ESI Act, 1948.

In this connection, it is informed that your claim has been carefully examined and -

(1) * you have been found eligible for Unemployment Allowance for the period from _____ to _____

(2) * you have not been found eligible for unemployment allowance due to following reason(s):

i)

ii)

*You are advised to contact the Branch Office _____ to collect your Unemployment Allowance immediately.

* Score out whichever is not applicable.

Yours faithfully,

For REGIONAL DIRECTOR

Copy to:

Branch Manager, Branch Office _____ for information and necessary action.

For REGIONAL DIRECTOR

REGIONAL OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

No.

Dated:

To,

Dr.
IMO Incharge'
ESI Dispensary/Insurance Medical Practitioner

Subject: Provision of Medical Benefit U/s 19 of ESI Act, 1948.

Sir,

It is informed that Shri/Smt./Km. _____ Ins.
No. _____ has ceased to be in the insurable employment on account of retrenchment, closure
of factory/estt., permanent invalidity arising out of non-employment injury. Accordingly, he/she has applied
for unemployment allowance under "Rajiv Gandhi Shramik Kalyan Yojna."

He/she has been found eligible for the unemployment allowance as well as for medical benefit under
the said section mentioned in the subject.

He/she and his/her family may be provided medical benefit at the scale provided under the Act for the
period from _____ to _____.

Yours faithfully,

MANAGER

COPY TO: AMO/DMS

REGIONAL OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

PERIODIC CLAIM FORM FOR UNEMPLOYMENT ALLOWANCE

I _____ s/w/d/ of Sh.
_____ Ins. No. _____ having been sanctioned
unemployment allowance under "Rajiv Gandhi Shramik Kalyan Yojna" vide Regional Office
_____ letter _____ No.
_____ dated _____ claim
unemployment allowance for the period from _____ to
_____.

I declare that :

1. I have not taken up any gainful employment during the above period.
2. I am not in receipt of any other similar benefit admissible under the provisions of any other enactment.
3. I have not attained the age of superannuation or of 60 (sixty) years during the period of claim.
4. I have not been convicted u/s 84 of ESI Act.
5. I have not been rendered unemployed due to voluntary abandonment of employment, voluntary/pre-mature retirement, etc.
6. I have not been dismissed/terminated under disciplinary action.
7. I have not challenged the closure/retrenchment in any court of law.

I further undertake to repay the whole amount forthwith on demand by the ESIC if it is discovered at any time that I was not lawfully entitled to the same.

Dated :

Signature of thumb impression
of claimant

Permanent address _____

IMPORTANT:-

Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for himself or for some other person, commits an offence punishable with imprisonment for a term which may extend to six months or with fine upto Rs.2000/- or with both.

HQRS. CIRCULAR No. N-11/12/2003-Bft.II/VOL – II, Dated 9th FEBRUARY, 2009

Sub: "Rajiv Gandhi Shramik Kalyan Yojana"

12.E.12 In order to provide Social Safety Net to the Insured Persons who are rendered jobless due to retrenchment, closure of factory/establishment or permanent disablement of at least 40% arising out of non-employment injury, the ESI Corporation had introduced a new scheme called "Rajiv Gandhi Shramik Kalyan Yojna" w.e.f. 01.04.2005. Keeping in view the various feedbacks received from the stake holders, changes have been made in this scheme with a view to provide more benefits to the Insured Persons and to simplify the procedures so that the benefits are available in a hassle free manner. After the changes made in this scheme and the simplification of the procedure, the scheme " Rajiv Gandhi Shramik Kalyan Yojna" as it stands on 01.02.2009 is as follows:-

- (1.) The terms, 'closure' and 'retrenchment' shall have the meanings assigned to them under the Industrial Disputes Act, 1947 (14 of 1947) and according to provisions of sub-section-(24) of Section -2 of the ESI Act, 1948.
- (2.) The term "permanent invalidity" shall mean permanent disability arising out of non-employment injury of 40% or more, as certified by a Medical Board constituted by the Central or State Governments.
- (3.) The person should have been, **an insured person**, under the ESI Act on the date of loss of insurable employment, on account of closure of the factory or establishment, retrenchment, or permanent invalidity arising out of non-employment injury.
- (4.) Insured person should have contributed under the ESI Scheme, for a minimum period of **three years** prior to loss of employment.
- (5.) Unemployment Allowance shall cease to be payable **from the date the insured person is re-employed elsewhere**.
- (6.) Only the insured person, who becomes unemployed as stated under (1) above, on or after 1st April, 2005, shall be entitled to receive Unemployment Allowance.
- (7.) The Unemployment Allowance can be availed of in one spell or in different spells of unemployment provided that **each such spell shall not be less than one month**.
- (8.) The Unemployment Allowance **shall not be combined** with sickness benefit, maternity benefit or disablement benefit for temporary disablement for the same period. The insured person in receipt of any of these benefits during the same period shall, however, **be entitled to choose** which benefit he/she wishes to avail of.
- (9.) The payment of Unemployment Allowance shall be **subject to the provisions of Section 61 of the ESI Act, 1948**.
- (10.) The Unemployment Allowance is payable for a **maximum period of twelve months** during the entire insurable employment of the IP/IW.
- (11.) **The periodicity of all the existing beneficiaries as on 01.02.2009 will stand extended to a total of Twelve Months**.
- (12.) Daily rate of Unemployment Allowance is **equivalent to the Standard Benefit** Rate corresponding to the average daily wages drawn by the IP/IW during the last four completed contribution periods, immediately

preceding the date of unemployment.

- (13.) Also, during the period for which, the IP /IW is entitled for Unemployment Allowance, he /she is eligible for medical care for himself/herself and his/her family from the ESI Hospital /Dispensary, Panel doctors, clinics, etc., to which he/she was attached prior to the date of loss of employment.
- (14.) Similarly, the **Medical Benefit** available to the IP/IW and his/her family members under this Scheme **also stands extended** from the existing period of six months to that of **twelve months** w.e.f. 01.02.2009.
- (15.) Applications for Unemployment Allowance should be submitted by the IP/IW **within six months from the date of loss of employment** due to closure/retrenchment or non-employment disability of not less than 40%, as the case may be.
- (16.) The cases in respect of Insured Persons where the Trade Union has gone to Court and Insured Person himself is not a party, may also be considered **after taking an undertaking** from the Insured Person that in case he/she receives the wages for the period of unemployment, he will refund the unemployment allowance, received by him, to ESI Corporation.
- (17.) The certificate of closure in Form UA-2 may also be accepted from employer if he submits the **return of contributions** under Regulation 26 (b) on permanent closure of the factory/establishment.

This is in supersession of all the earlier orders, instructions, etc., issued for this Scheme.

F. VOCATIONAL REHABILITATION SKILL DEVELOPMENT SCHEME UNDER RAJIV GANDHI SHRAMIK KALYAN YOJANA

The salient features, terms and conditions and other issues of this Skill Development Scheme are detailed below :-

Eligibility Conditions

12.F.1 The IP/IW should be in receipt of unemployment allowance under Rajiv Gandhi Shramik Kalyan Yojana. The entitlement for unemployment allowance is re-iterated as under:-

- (a) The person should have been IP for the last five years prior to the loss of employment. He/she should also be IP on the date of being rendered jobless.
- (b) The IP/IW should be jobless due to retrenchment or closure of factory/establishment or permanent invalidity arising out of non-employment injury of not less than 40%.
- (c) The IP/IW should not be in gainful employment.

Duration of Training

12.F.2 (a) Short duration course of a few weeks or other longer duration Courses of upto six months are allowed.

- (b) The period of training must be within the period when he is receiving Unemployment Allowance that is, it should not go beyond the last date of RGSKY.

Disqualification

12.F.3 (a) If IP/IW secures gainful employment during the course of training he/she may opt whether he/she shall continue the training. In case he/she prefers to take up a job, he/she shall not be entitled to training.

- (b) An Insured Person who ceases to be a beneficiary under Rajiv Gandhi Shramik Kalyan Yojana shall not be eligible for this scheme, but a training course, once started, shall be allowed to be completed if the IP/IW is not in gainful employment.

- (c) The training under this scheme shall be admissible only once in entire life of an IP/IW.

Fees etc.

12.F.4 The IP/IW has to secure admission as per the entry norms of the respective institute and the Corporation will pay the entire fee charged and will also reimburse second class to and fro rail/bus fare for the IP/IW who has to travel for attending the training programme at Advanced Vocational Training Institute (AVTI).

Procedures to be followed

12.F.5 (1) IP/IW receiving UA and desirous of upgrading his/her skill shall be referred to the nearest "Advanced Vocational Training Institutions" under the DGET, MoL&E, Government of India where the course of his choice is available.

- (2) The IP/IW shall be required to apply in the prescribed form in duplicate to the Regional Director concerned through the Branch Office from where he is receiving Unemployment Allowance.

- (3) The application form shall be made available to all the IPs/IWs by the Branch Office alongwith claim form of Unemployment Allowance. The Insured Persons should also be properly briefed by the Branch Manager/Staff about the skill upgradation option. Specimen of form is at **Annexure 'A'**.
- (4) On receipt of the application from the IP/IW, the Branch Manager shall verify the particulars given by the IP to ensure that they do not vary from the particulars given at the time of claiming Unemployment Allowance and forward one copy of application form **Annexure 'A'** to the RD/JD(I/c) within five working days for further necessary action.
- (5) After receipt of the application from the Branch Office, the Regional Director/JD(I/c) will decide entitlement of the IP/IW for skill upgradation training in consultation with the F & A/c Branch. For keeping record and audit purpose, relevant details will be entered in a prescribed register **Annexure 'B'**, and thereafter the IP will be referred to the nearest "Advanced Vocational Training Institution" where facility for training in the trade chosen by eligible IP/IW is available along with a forwarding letter **Annexure 'C'**. Original copy of this letter will be handed over to the IP and another copy will be sent to the AVTI by registered/speed post. Three copies of standard reply (**Annexure 'D'**) to be furnished by the "Advanced Vocational Training Institution" certifying that the IP has successfully undergone the training will also be handed over to the IP. After the training is over, the AVTI concerned will return a copy of the standard letter through the IP and another copy by post, retaining the third copy with them. **The fees payable to the Advanced Vocational Training Institute shall be paid by the RO/SRO direct to the AVTI in the mode prescribed by them.**
- (6) The IP, after completing the training, will claim re-imburement of Bus/Train fare as per actuals duly supported by a letter from the AVTI in form **Annexure 'D'**. The amount admissible will be paid by the Branch Office from where the IP is in receipt of Unemployment Allowance under Rajiv Gandhi Shramik Kalyan Yojana on the prescribed claim form (**Annexure 'E'**).
- (7) All payment made under this scheme will be entered in red ink under the signature of Branch Manager in the register for Unemployment Allowance under Rajiv Gandhi Shramik Kalyan Yojana and the ledgersheet of the IP/IW.
- (8) The expenditure incurred under this scheme shall be booked under the head "Other Benefits" with a distinct sub-head "Unemployment Allowance" {"Fees for Skill Development under Rajiv Gandhi Shramik Kalyan Yojana"}.
- (9) All the Branch Managers may please be briefed suitably by the RDs/JDs(I/c)for smooth launching and implementation of the Scheme through issue of instructions, meetings etc.
- (10)Wide publicity of this Scheme may please be arranged through advertisements in local dailies, meetings, seminars etc.
- (11)Regional Director/Joint Director(I/c) will locate 'Advanced Vocational Training Institute' situated within his respective region/sub-region and a consolidated list of AVTIs be made available to all the Branch Offices. The list of AVTIs will be displayed on 'Notice Board' for IPs' ready reference.
- (12)A Quarterly report may please be sent indicating No. of IPs/IWs enrolled and amount of fees paid to AVTIs.
- (13)Wide publicity may be given by all concerned to this Scheme which differs from a somewhat similar scheme appearing against item B of this Chapter, the main one being that the said scheme is meant for insured persons suffering 40% or more loss of earning capacity from an employment injury only.

ANNEXURE 'A'

To,

The Regional Director,
ESI Corporation,
Regional Office,
_____.

Through
Manager, Branch Office,
_____.

Sub: Vocational Rehabilitation Skill for Insured Person in receipt of Unemployment Allowance under the scheme of Rajiv Gandhi Shramik Kalyan Yojana.

Sir,

I intend to enroll myself for upgrading my skill through the scheme noted above. My particulars are as under:-

1. Name of IP & Insurance Number: _____
2. Father's/Husband's Name: _____
3. Date of retrenchment/closer of factory/Non-employment injury leading permanent invalidity not less than 40%: _____
4. Location of injury and percentage of disability: _____
5. Percentage of loss of earning capacity in case of disability: _____
6. Name of Branch Office from where Unemployment Allowance under Rajiv Gandhi Shramik Kalyan Yojana is being received and the date thereof: _____
7. Residential Address: _____

Applicant's Signature

Applicant's Name:

BRANCH OFFICE _____

EMPLOYEES' STATE INSURANCE CORPORATION

'VOCATIONAL REHABILITATION SCHEME FOR UPGRADING SKILL OF IPs RECEIVING UNEMPLOYMENT ALLOWANCE'

Name of IP	Father's/Husband's Name	Insurance No.	Name, Code No. & Address of Factory/Estt. Last employed	Date of Unemployment due to retrenchment/closure of factory/permanent invalidity on account of non-employment injury not less than 40%	Starting date of UA & submission of the application by the IP/IW at Branch Office for trg.	Date of verification and reference to RO	Date of reference to AVTI by RO and the name of the AVTI concerned	Nature of Trade & duration of training	Date of communication to IP/IW for undergoing training	Date of submission of claim by the IP/IW at Branch Office	Rate of fare claimed by the IP/IW and the amount paid to IP/IW with days for which the amount has been paid	Remarks, if any
1	2	3	4	5	6	7	8	9	10	11	12	13

From
Regional Director/Director/Jt. Director(I/c)
Regional/Sub-Regional Office
ESI Corporation

To
The Supdt./Office Incharge,
Vocational Rehabilitation Centre,

Sub: Vocational Rehabilitation Training to Sh._____ Ins.No._____

Sir,

As you are aware that the ESI Corporation provides medical benefit as well as cash benefits to IPs in case of sickness, maternity, disablement and death. The Corporation also provides 'Unemployment Allowance' under 'Rajiv Gandhi Shramik Kalyan Yojna' for twelve months to IPs who are jobless due to retrenchment/closure of factory/permanent invalidity out of non-employment injury not less than 40%. The Corporation, believing in their ability, has decided to provide training to IPs receiving Unemployment Allowance under Rajiv Gandhi Shramik Kalyan Yojana and volunteer to enhance their ability.

We understand that your Advanced Vocational Rehabilitation Institute provides training for shorter period of 1-2 weeks duration to enable the IPs to retain gainful activity. We are, therefore, referring Sh._____ Ins. No._____ to your centre requesting to enroll him for training at your Institute in _____. In case, he is enrolled for training, the same may be informed to this office with duration of training and the date from which the IP is required to report at your centre for the said training.

This Office will pay the entire fee payable for the course and such, the amounts and mode of payment may please be sent to this office.

After completion of the training of Sh._____ at your Intstitute, you are also requested to return the enclosed letter in original duly filled in through the trainee and the duplicate by registered post under your rubber stamp for our records.

Yours sincerely,

(_____)
RD/Director/Jt. Director

Annexure-'D'

From:

To

The Regional Director/Director/Jt. Director,
ESI Corporation
Regional/Sub-Regional Office

Sub: Vocational Rehabilitation Training to Sh._____ Ins. No._____.

Sir,

With reference to your letter No._____ dated_____ on the subject noted above it is informed that Sh._____ Ins. No. _____ has undergone the training at this centre from _____ to _____ in trade _____ and has completed the training satisfactorily. He has attended the training on all working days except for _____.

Yours faithfully,

(Superintendent)

Vocational Rehabilitation Centre

SEAL:

Annexure-‘E’

Name:
Ins. No.:

To
The Branch Office Manager
ESI Corporation

Sub: Request for claim for conveyance allowance/Bus or train fare/cash assistance.

Sir,

With reference to RD's letter No. _____ dated _____ referring me for undergoing Vocational Training at AVTI _____, I have participated in the training for the period from _____ to _____ except _____.

In this connection, I claim reimbursement of rail/bus fare for self/attendant as per particulars given hereunder.

1. For self Rs. _____ @ Rs. _____ per day for _____ days
2. For attendant Rs. _____ @ Rs. _____ per day for _____ days

Yours faithfully,

Signature of the Claimant
Full Name:

CHAPTER XIII
ENTITLEMENT TO MEDICAL BENEFIT
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at Branch Offices**

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CHAPTER XIII

ENTITLEMENT TO MEDICAL BENEFIT

PART – I Receipt of Returns of Contributions(RCs) at Branch Offices

Provisions in the Regulations.

13.1.1 Regulation 26(1) of the E.S.I. (General) Regulations, 1950, requires the employer of every covered factory/establishment to send the return of contributions (RC) in quadruplicate in form 6 alongwith receipted copies of challans for the amounts deposited in the bank, to the appropriate office by registered post or messenger, in respect of all employees for whom contributions were payable in a contribution period, so as to reach that office -

- (a) within 42 days of the termination of the contribution period to which it relates;
- (b) within 21 days of the date of permanent closure of the factory or establishment, as the case may be;
- (c) Within 7 days of the date of receipt of requisition in that behalf from the appropriate office.

Receipt of RCs by Branch office

13.1.2 Hitherto, the appropriate office was the Regional Office but with the issue of Director General's notification No. A-12/13/1/87-Ins.II, published at page 1012 of Gazette of India, Part III, Section 4 dated 15.4.2000, every Branch Office has been declared the appropriate office for the purpose of Regulation 26(1) quoted above. Thus, returns of contributions, alongwith receipted bank challans, must henceforth be submitted by every employer to the Branch Office to which his factory/establishment is attached.

13.1.3 Every Branch Office, irrespective of whether it is situated within the same city in which the Regional Office exists or is at outstations, is empowered, and is required, to receive returns of contributions from employers of factories/establishments attached to it and to perform functions connected therewith. Certain functions would be common in case of every Branch Office wherever situated, viz., receipt of RCs and their checking and forwarding etc., and these functions, based on a study made by the Management Services Unit (MSU) of ESIC (Hqrs.) and as modified by Hqrs. instructions No. 36/2000 are given below:-

Stage I: LDC/Receipt Clerk/Other Functionary.

- 1) Receives only those RCs which are accompanied with all the relevant payment challans.
- 2) Tallies dates and amounts of each of the accompanying payment challans with those given in the RC.
- 3) Puts date of receipt on all 4 copies of RC by dater/date stamp and indicates number of pages of RC on its top. If the RC is received late, i.e., more than 42 days after the end of the contribution period, each copy will be boldly stamped LATE by a rubber stamp (suggested size: 1-1/2" x 2"). However, if the last date as given in the regulations happens to be a holiday, the next working day will be deemed as the last due date of receipt of RC.
- 4) (i) If brought by hand, gives provisional acknowledgement on the 4th copy "Receipt of RC acknowledged subject to verification" to the bearer.
(ii) If received by post, sends the 4th copy with the above certificate to employer by post.
- 5) Makes entry in diary register of RCs on the same day of receipt of RC in the following proforma whereafter passes on the RC(all copies) to the next higher level.
- 6) Writes diary number/serial number of diary register on first page of every copy of RC.

Sl.No.	Code No.	No.of Challans	Total No.of IPs*	Date of despatch of 1 st copy to RO
1	2	3	4	5

* Only those who qualify for medical benefit during the corresponding benefit period should be entered.

Stage II: UDC/Checker/Head clerk:

- 7) Gets rubber stamp of his name affixed on all three copies of each RC and signs on one side of each sheet of RC
- 8) Sends all copies of RC to Manager for his signature.

Stage III : Branch Manager:

- 9) Checks the work so far done and signs on the 1st page of each copy of RC and returns to the lower level.

Stage IV: Dealing /Receipt Clerk:

- 10) Removes first copies of each RC, prepares a forwarding letter in duplicate addressed to Regional Director, Cash Contribution Section (specimen at annexure-I) and after obtaining Manager's signatures thereon, dispatches the bundles of first copies of RCs alongwith receipted bank challans under registered post to Regional Office immediately and in any case within one week of receipt of RCs. Writes the date of despatch of 1st copy to RO under column 5 of the diary register. One copy of the forwarding letter will be received back as acknowledgment from Regional Office and filed in a folder.

- 11) At the close of every working day, draws up a summary as follows :-

- 1) Number of RCs received during the day for CP just ended.
- 2) Progressive number of RCs received.
- 3) Total progressive number of IPs as per column 4.
- 4) Number of RCs received for earlier CPs, if any:

<u>CP ended</u>	<u>Number received</u>
- 5) Number of IPs included therein.

Stage V: Checker/HC-To-Manager:

- 12) Checker/HC checks the summary, puts his initials, forwards it to Manager who signs it.

Stage VI : Visiting Inspecting Officer:

- 13) Calls for the RC diary register, inspects it to see that procedure is being followed fully by the Branch Office, and signs it with date in token of having inspected it.

Disposal of RCs by Branch Office

13.1.4 The process of receipt of RCs as given hereinabove is closely linked with the process of entitlement to medical benefit provided in the second part of this Chapter. But, before the second part begins, the RCs received by the Branch Offices must be dealt with. Since the procedure for dealing with them would differ in case of differently situated Branch Offices, the same is described below for guidance:

(I) Outstations centers having one Branch office

The Branch office will retain 2nd and 3rd copies of RC with itself. 2nd copies will be used for making entries in ESIC-38 registers whereafter these will be passed on to dealing clerks for custody. 3rd copies will be placed in the personal custody of the Branch Manager as per present procedure.

(II) Branch Offices situated in the same city as Regional Office

Same as in previous para, except that the work connected with ESIC-38 registers will be performed only at Regional Office.

(III) Outstations centres having more than one Branch Office

Regional Office will designate one of the Branch Offices in the outstations center for performing work connected with Regulation 103-A. Other Branch Offices in that center will send the 2nd copy of each RC duly authenticated by the Branch Manager to the designated Branch Office, under a challan in duplicate (specimen at annexure-II). In the diary register, the date of dispatch of the 2nd copy to the designated Branch Office will be indicated by adding a column 6 "date of dispatch of 2nd copy to the designated Branch Office". The duplicate copy of challan when returned by the designated Branch Office duly receipted will be filed in a separate folder. The designated Branch Office will maintain ESIC-38 registers and will also perform functions connected with entitlement/disentitlement to medical benefit under Regulation 103-A for all IPs in the center.

(IV) Since the appropriate Branch Office which received the RCs will be left with only one copy, i.e., the 3rd copy while it is actually required to maintain 2 copies, it should get photocopies of the RCs in its possession and these photocopies should be authenticated as true copies by the Branch Office Manager and passed on to dealing clerks for benefit payments. He should retain the original 3rd copy in his own custody.

Certificate of contributions payable (CCP) from defaulting employers

13.1.5 Every Branch Office should maintain a 'watch over' register of RCs in respect of employers attached to it, as per proforma suggested at Annexure-III. Names, addresses and code numbers of existing factories/establishments attached to the Branch Office should be entered in it in ascending order. Similar particulars of new factories/establishments as well as those of locally situated HO/BO/sales office of a factory or estt. should also be entered in it on receipt of intimation from Regional Office. Entries of RCs received from every employer should be made in this register simultaneously with the entries in the Branch Office diary described in para 13.1.3 (5) above.

13.1.6 At the end of about 2 months from the date of expiry of a CP, i.e., about a month before the start of the corresponding benefit period, the Branch Office should review this register and note down on a separate sheet the names of employers who have failed to submit the RCs and call upon those of them who are known to be continuing their operations, to submit the RCs. If an employer is not in a position to submit the RC, he should be asked to submit at least the certificate of contributions payable (CCP) in respect of all his covered employees. A specimen of the letter to be addressed to the employer is at Annexure IV. This action, and its follow up where needed if taken timely would save the Branch Office and the employer from much labour involved in issue of ESIC-37 and ESIC-71, etc., after the start of the benefit period.

13.1.7 A CCP, if submitted in lieu of an RC, must also be submitted by the employer in quadruplicate to the Branch Office. As soon as it is received, it will be fully checked and, if found in order, entries will be made in red ink in the watch over register only.

13.1.8 At the start of the BP, the BO will submit to RO a list of those employers from whom RCs have not been received by then. A suitable remark, e.g., 'CCP received' will be added against the names of those employers who have submitted CCPs in lieu of RCs.

Disposal of CCPs

13.1.9 The procedure for disposal of CCPs, including action under Regulation 103-A, will be on the lines similar to those provided in para 13.1.4 above, with the following exceptions:

- (a) The first copy of every CCP shall be sent to the concerned Revenue Branch in the Regional Office for initiating recovery action against the defaulting employer.
- (b) Every cash benefit payment made on the basis of CCP will be duly entered in ESIC-71 register, with suitable remarks about CCP. Entries thus made will be verified with RC when received/employer's record.
- (c) RC when received will be duly compared with the CCP to set right any wrong entitlement and payment.
- (d) The RC (first copy), when received, shall also be forwarded, like the CCP sent earlier, to the Revenue Branch, giving a proper reference of the earlier letter so as to ensure that recovery action is stopped in time.

13.1.10 The rest of the action for (i) watch over receipt of RCs, (ii) recovery of contributions, (iii) prosecution, etc., at the level of the Regional Office will be as detailed in Hqrs. Memo No., V.33/15.1.95-Ins.IV dated 6th October, 1995.

PART - II Procedure for entitlement to medical benefit

Importance of medical benefit

13.2.1 Medical benefit is just one of the five recognised benefits provided under the ESI Scheme. But it has features unique to itself, none of which is found in other benefits, such as the following:

- (i) Medical benefit not only permeates every other benefit but the certification part of medical benefit forms the edifice on which rests the whole framework of cash benefits under the E.S.I. Scheme.
- (ii) Medical benefit is the only benefit which is available in kind.
- (iii) This benefit is available to the needy according to the need and not according to the rate of wages or contributions paid by the person in need.
- (iv) This is the only benefit which is also provided to members of the family of an insured person.

This benefit is open to considerable misuse through impersonation and is at times availed by persons exited from the Scheme. It should thus be clear that utmost care is required to ensure that only persons entitled to medical benefit under the Scheme receive this benefit.

Provisions in the Act and the Rules

13.2.2 Section 56(3) of the E.S.I. Act says that "a person shall be entitled to medical benefit during any period for which contributions are payable in respect of him or in which he is qualified to claim sickness benefit or maternity benefit or is in receipt of such disablement benefit as does not disentitle him to medical benefit under the regulations."

13.2.3 Entitlement of sickness benefit is determined by the provisions of Rule 55(1) of ESI (Central) Rules, 1950 which provided, prior to 19.9.1998, that a person would be entitled to sickness benefit in a benefit period if he had paid contributions for not less than half the number of days in the corresponding contribution period.

13.2.4 However, w.e.f. 19.9.1998, Central Rule 55(1) was amended whereby an insured person having paid contribution for only 78 days in a contribution period becomes entitled to sickness benefit in the corresponding benefit period.

13.2.5 Further, w.e.f. 8.4.2000, the said Rule 55(1) has been further amended by addition of a proviso which reads as under :-

"Provided that in case of a person who becomes an employee within the meaning of the Act for the first time and for whom a shorter contribution period of less than 156 days is available, he shall be qualified to claim sickness benefit if the contributions in respect of him were payable for not less than half the number of days available for working in such contribution period."

13.2.6 It will be clear from a careful reading of the above Rule that any person who has paid contributions for 78 days in a contribution period is entitled to sickness benefit during the corresponding benefit period. In addition, a new entrant having worked in his first contribution period for less than 156 days from the date of his joining, will also be entitled to sickness benefit during the corresponding benefit period provided he has paid contributions for not less than half the number of days from the date of his joining in the contribution period. (A 'corresponding benefit period' in respect of such a new entrant will commence 9 months after the date of his entry).

13.2.7 *Vide* section 56(3) quoted in para 13.2.2 above, a person entitled to sickness benefit during a benefit period is also entitled to medical benefit. Further, since contributions are payable from the date of his employment in a covered factory/establishment, it follows that Section 56(3) entitles an insured person to medical benefit from the date of his employment in a covered factory/establishment and he continues to be so entitled during the period of his employment.

Provisions in the Regulations

13.2.8 Proviso to Section 56(3) says that a person in respect of whom contributions ceased to be payable under the Act may be allowed medical benefit for such period as may be provided under the regulations. Regulation 103-A(1) which was framed in fulfillment of the aforesaid proviso, says that "a person on becoming an insured person for the first time shall be entitled to medical benefit for a period of 3 months: provided that where such a person continues for 3 months or more to be an employee of a factory or establishment to which the Act applies, he shall be entitled to medical benefit till the beginning of the corresponding benefit period."

13.2.9 Regulation 103-A(1) means, in other words, that a person who leaves employment after having served as an employee for less than 3 months in a covered factory/establishment becomes disentitled to medical care after 3 months from the date of his entry. This is the reason why the temporary identification certificate (TIC) issued to a new entrant is valid for treatment only for 3 months, and the permanent identity card is issued only to a person whose employment as an 'employee' in a covered factory/establishment has continued for 3 months or more. Branch Office should ensure the issue of permanent identity cards only to those persons whose employment continues for three months or more.

13.2.10 *Vide* proviso (i) to Regulation 103-A(2), where a person suffering from any of the following diseases, before the commencement of the spell of sickness in which any such disease was diagnosed, being in continuous service for a period of 2 years or more or where he did not have 2 years' continuous service but by virtue of relaxation granted by the authority competent in this behalf, the insured person qualifies to claim extended sickness benefit, he shall be entitled to medical benefit till the end of the relevant extended benefit period :

New list of long-term diseases

I. Infectious Diseases

1. Tuberculosis
2. Leprosy
3. Chronic empyema
4. Bronchiectasis
5. Interstitial lung disease
6. AIDS.

II. Neoplasms

7. Malignant diseases

III Endocrine, nutritional and metabolic disorders

8. Diabetes mellitus with proliferative retinopathy/diabetic foot/nephropathy

IV Disorders of nervous system

9. Monoplegia
10. Hemiplegia
11. Paraplegia
12. Hemiparesis
13. Intracranial space occupying lesion
14. Spinal cord compression
15. Parkinson's disease
16. Myaesthesia gravis/neuromuscular dystrophies

V Disease of eye

17. Immature cataract with vision 6/60 or less
18. Detachment of retina
19. Glaucoma

VI Diseases of cardiovascular system

20. Coronary artery disease
 - a) Unstable angina
 - b) Myocardial infarction with ejection less than 45%
21. Congestive heart failure
 - Left
 - Right
22. Cardiac valvular diseases with failure/complications
23. Cardiomyopathies
24. Heart disease with surgical intervention alongwith complications.

VII Chest diseases

25. Chronic obstructive lung disease (COPD) with congestive heart failure (cor pulmonale)

VIII Diseases of the digestive system

26. Cirrhosis of liver with ascitis/chronic active hepatitis("CAH")

IX. Orthopedic diseases

27. Dislocation of vertebra/prolapse of intervertebral disc.
28. Non-union or delayed union of fracture
29. Post traumatic surgical amputation of lower extremity
30. Compound fracture with chronic osteomyelitis

X. Psychoses

31. Sub groups under this are listed for clarification
 - a) Schizophrenia
 - b) Endogenous depression
 - c) Manic depressive psychosis (MDP)
 - d) Dementia

XI Others

32. More than 20% burns with infection/complication
33. Chronic renal failure
34. Reynaud's disease/Burger's disease

13.2.11 The rest of the provisions in the Regulation 103-A concerning entitlement to medical care remain unchanged and are described in the succeeding paragraphs. But, before doing so, it appears necessary to clarify the term 'relevant extended benefit period' used in the proviso (I) to Reg..103-A(2) quoted in para 13.2.10 above.

13.2.12 Relevant extended benefit period in respect of medical care under the aforesaid proviso of Regulation 103-A corresponds to the 'extended sickness benefit period' which under Para 7 of Corporation's Resolution dated 5.12.1999 has been clarified as a period of 3 years. -

- a) from the date of start of the spell of sickness in which the IP was diagnosed as suffering from tuberculosis and
- b) from the date of diagnosis in the spell of sickness in case of any other listed disease.

13.2.13 The manner in which the period of 2 years' continuous service is to be reckoned [proviso (I) referred to in para 13.2.10 above] as well as the procedure for relaxation thereof (where 2 years' service condition is not fulfilled by the patient) is described in Chapter VIII (Procedure) of this Manual.

13.2.14 Regulation 103-A(3) says that an insured person whose entitlement to medical benefit has ceased under this Regulation shall again be entitled to medical benefit from the date of his re-employment as an employee under the Act by a factory or establishment to which the Act applies, if he produces a certificate from the employer in the form which may be specified by the Director General for the purpose. Such an insured person shall, unless he is covered by Sub-Regulation(2), be entitled to medical benefit till the commencement of the benefit period corresponding to the contribution period in which he is re-employed.

13.2.15 As per Regulation 103-A(4), an employer shall, on demand, issue the certificate referred to in sub-regulation(3) to an employee who has been employed by him after cessation of his previous insurable employment.

Entitlement procedure

13.2.16 The process of entitlement to medical benefit begins with the filling up and receipt of declaration forms of new entrants from the employer of a covered factory/establishment, allotment of insurance numbers, setting up of records, etc. This work is known as 'Registration' and it is already being done at each Branch Office.

13.2.17 Follow up work, i.e., continued entitlement or otherwise to medical benefit for IPs during the current or corresponding benefit period, also popularly known as '103-A work' was hitherto being handled exclusively at the Regional Office. However, this work has now been re-allocated on the following lines :-

- (i) At outstations centers having only one Branch Office, this work will be performed in the said Branch Office.
- (ii) For Branch Offices situated in the same city where the Regional Office is located., this work continues as before at the Regional Office.
- (iii) In outstation centers having more than one Branch Office, the work will be performed at a Branch Office designated by the Regional Office on behalf of all other Branch offices situated at or near that center.

ESIC-38 registers

13.2.18 Regional Office will transfer ESIC-38 registers to Branch offices designated for the purpose. It will retain only the registers of Branch Offices situated locally in the city. The designated Branch Offices shall continue to maintain these registers. 'Designated Branch Office' here means the Branch Office which is entrusted with the task of maintenance of ESIC-38 registers and 103-A work in general. 'BO' concerned means the Branch Office to which the IPs are attached.

13.2.19 Each page of ESIC-38 register (specimen at annexure V) contains insurance numbers entered in the ascending order. After the last entry, entry of next insurance number is made in this register on the basis of the index sheets received monthly from every Branch Office. These index sheets must contain the name of dispensary chosen by each IP/IW as well as the date of his entry. This information will also be posted in the ESIC-38 register by opening columns therein. Any change in the name of dispensary should be duly intimated by the concerned Branch Office to the office maintaining ESIC-38 registers.

13.2.20. Every page in ESIC-38 register contains a number of columns each representing a contribution period. Dates of each contribution period are given on top of each column. Entitlement or otherwise of an IP during a benefit period corresponding to the contribution period on hand is represented by various symbols used in this register. These symbols are recorded based on information supplied by the employer in respect of each IP whose name is included in the RC sent by him. Symbols generally in use in the ESIC-38 register are 'E', 'X', 'N' and 'S'. The manner of writing them is described below :-

Number of days for which wages paid (i.e. contributions payable) as shown in column -4 of RC	Symbol to be used	Entitlement or otherwise to medical care during corresponding benefit period (from its beginning).
--	-------------------	--

(1) In case of a new entrant who became an 'employee' when less than 156 days were left in his first contribution period :

(a) Not less than half the number of days in CP	'E'	Clearly entitled
(b) Less than half the number of days and –		
i) employer says 'Yes' in column 7-A, which means IP is continuing in service.	'S'	Allowed to be entitled
(ii) employer has recorded nothing or 'No' in answer to column 7-A (See annexure X)	'X'	Disentitled .

(2) In case of others (i.e. old entrants):

- (a) Not less than 78 days 'E' Clearly entitled
- (b) Less than 78 days and –
- (i) employer says 'Yes' in column 7-A, which means IP is continuing in service 'S' or 'X' Allowed to be entitled – 'S' if he was 'E' in preceding period; and otherwise, 'X' – Not entitled
- (ii) employer has recorded nothing or 'No' in answer to column 7-A 'X' Disentitled.

Other Symbols

- (3) Employer has omitted a name from the RC or RC is not received. 'N' Disentitled
- (4) - do - 'NN' if 'N' or 'S' was recorded in immediately preceding column. Disentitled
- (5) In all cases not covered by (1),(2),(3) & (4) above. ' _ ' is marked in current CP. Exit continues.

6) A few sample entries to be made in ESIC-38 register and the action required on each entry, are given below for guidance:

Ins.Nos.	Previous 4 CPs ended(assumed)				Current CP ended 9/2000	Entitlement	Included in Live list/omitted
	9/98	3/99	9/99	3/2000			
3400001	E	E	E	E	E	Entitlement continues	Live list.
02	E	E	E	E	S	Entitlement continues	Live list.
03	E	E	E	E	X	Disentitled	Omitted
04	E	E	E	E	N	Disentitled	Omitted
05	E	E	E	S	E	Entitlement continues	Live list
06	E	E	E	S	S	Disentitled	Omitted
07	E	E	E	S	X	Disentitled	Omitted
08	E	E	E	S	N	Disentitled	Omitted
09	E	E	S	S	E	Re-entitled	Live list
10	E	E	N	S	E	Re-entitled	Live list
11	E	E	S	S	S/X/N	Exit continues	Omitted
12	E	E	N	S	S/X/N	Exit continues	Omitted

13	E	E	E	X	E	Re-entitled.	Live list
14	E	E	E	X	S/X/--	Exit continues	Omitted
15	E	E	X	--	E	Re-entitled	Live list
16	E	E	X	--	S/X/--	Exit continues	Omitted
17	X	--	--	--	--	Exit continues	If '—' marked for 6 CPs, delete Ins.No. in next register(Para 13.2.42)
18	E	E	E	N	E	Re-entitled.	Live list
19	E	E	E	N	S	Disentitled	Omitted
20	E	E	E	N	X	Disentitled	Omitted
21	E	E	E	N	NN	Disentitled	Omitted
22	E	E	N	NN	E	Re-entitled.	Live list
23	E	E	S	NN	S/X/--	Exit continues	Omitted
24	E	S	NN	--	E	Re-entitled.	Live list
25	E	N	NN	--	S/X/--	Exit continues	Omitted
26	NN	--	--	--	--	Exit continues	If '--' is marked for 6 CPs, delete Ins.No. in next register .
27	E	E	ESB case. Entitled upto _____(Date)in RED INK (Para 13.2.40)				

It will be observed from the above sample that an exit list for benefit period corresponding to the current CP will include the name and / or insurance no. of every I.P. who is –

- (i) marked 'X' or 'NN' in the current CP, or
- (ii) marked 'S' in current CP as well as 'S' in immediately preceding CP, or
- (iii) marked 'S' in current CP and 'N' in immediately preceding CP.

Live lists

13.2.21 Live Lists (proforma at Annexure VI) shall be issued in respect of insured persons who are entitled to medical benefit during current benefit period. Insured Persons as well as their families whose insurance numbers do not appear in the Live Lists will stand exited and debarred from medical benefit during relevant benefit period. The dispensary-wise/IMP-wise Live Lists will be issued to each dispensary/IMP by Regional Office/designated Branch Office after making entries in ESIC-38 register based on return of contributions for the contribution period under action. In cases where name of dispensary is not shown in return of contribution/ESIC-38 register, Live Lists in respect of such cases may be circulated to all concerned dispensaries in the area. The Branch Office will immediately write to concerned employer to report correct name of dispensary for such cases. On receipt of information from the employer or dispensary, the ESIC-38 register may be corrected to ensure proper reporting of dispensaries in Live Lists for next benefit period.

13.2.22 Only those IPs and their families whose ins. nos. appear in the Live List will be entitled for medical benefit during the current benefit period.

13.2.23 Main Live List will be prepared on the basis of entries made in ESIC-38 register after processing Return of Contributions received in time. This list will contain insurance numbers in ESIC-38 register. As regards 'S' cases, only those cases of 'S' category will be included where symbol 'E' is marked in preceding contribution period in the ESIC-38 register. This Live List will be issued in the form given in Annexure-VI. One month before the start of the next benefit period e.g., by 31st May and 30th November positively. Supplementary Live Lists will be prepared and issued monthly on the basis of entries made as per guidelines provided above in respect of return of contributions received late during ensuing remaining months in the benefit period.

13.2.24 Supplementary Live List may also include insurance numbers of all those insured persons for whom ESIC-37 forms are received from dispensary and verified from employer's record and found "Entitled" by the Branch Office/designated Branch Office/Regional Office. An insured person will be entitled to medical benefit on the basis of verified ESIC-37 till the end of relevant benefit period.

Procedure in panel areas

13.2.25 For areas where medical care is provided through the panel system, Live Lists will be sent by Regional Office/designated Branch Office to the AMO at least 2 weeks before the start of the corresponding benefit period. On receipt of the Live Lists, the AMO will rearrange the medical acceptance cards accordingly in the live run of each IMP. The AMO will also inform the IMP concerned who too will rearrange MREs of IPs now found entitled. Later, during the benefit period, supplementary Live Lists will also be sent to the AMO for re-entitlement of IPs to medical benefit for necessary action by him, followed by action by IMP on receipt of the supplementary list from the AMO.

Change of employment

13.2.26 Where symbol 'X' has been already written in respect of an IP in the CP on the basis of RC received from one employer, the RC received from another employer may possibly have included the same Ins. No., thus necessitating a change in the marking already appearing in the register. In such a case, a fresh symbol will need to be put in accordance with the information now available in respect of him based on the position furnished by both employers. The earlier entry made in ESIC-38 register will be neatly crossed and a new entry put in with full dated signature of HC, BM, or Branch Officer, as the case may be. The insurance number may then be included in Live List, if otherwise found 'Entitled'.

Entitlement certificate for medical benefit

13.2.27 Branch Managers may issue "Entitlement Certificate" on demand, in specific cases, by ESI medical authorities/IP.

ESIC - 37

13.2.28 A person who was earlier exited from medical benefit may have continued or rejoined service as an 'employee' in a covered factory or establishment. Such a person can become re-entitled to medical care on production of a certificate of continuing employment or re-employment in form ESIC-37 from his employer to his dispensary or to his panel doctor whereupon the IMO/IMP will restore medical benefit to the IP until the end of the current benefit period. The IMO/IMP will also remove his MRE from the 'exit run' and replace it in the 'regular run'. The IMO/IMP will send ESIC-37 to the Branch Office to which IP is attached and the said office will verify the contents of ESIC-37 with the employer's record and then send it to the designated Branch Office or the Regional Office, as may be applicable, who will make entry 'R' in the ESIC-38 register side by side with the entry already made.

13.2.29 The Regional Office/designated Branch Office will include the insurance numbers of these IPs in the supplementary Live List currently under issue and send a copy of it to the AMO/concerned dispensary for record/necessary action.

13.2.30 Sufficient number of blank ESIC-37 forms may be kept at each dispensary and with IMPs to avoid inconvenience to IPs/patients.

Action at the dispensary

13.2.31 (1) On receipt of Live Lists each dispensary will keep the Medical Record Envelopes in respect of the insured persons whose insurance numbers appear in the Live Lists in Regular Run and keep other MREs out of run separately.

(2) If a patient whose MRE is not in Regular Run visits dispensary for treatment he may be issued ESIC-37 to be filled up by his employer and the patient may be given treatment after giving suitable remarks (about ESIC-37 issued) on his MRE. He should be advised to bring filled up ESIC-37 for continuing treatment. On receipt of filled up ESIC-37, it may be critically scrutinised for complete entries and signature and stamp of employer etc. and if found correct, his MRE may be kept in Regular Run. It may be noted that the IP and his family members will be entitled for medical treatment only upto the current benefit period.

(3) As stated in para 13.2.28 above, form ESIC-37 must be sent to concerned Branch Office for verification within SEVEN days and treatment of the patient may continue till Manager, Branch Office investigates and sends his report.

(4) If the IP is found non-entitled on verification, suitable remarks should be given on the MRE and treatment shall be discontinued till further orders.

(5) MREs of IPs continuing medical treatment due to Extended Sickness Benefit/Maternity/TDB may also be placed in Regular Run with suitable remarks.

(6) MREs in respect of IPs who are entitled to medical care under Rule 60/61 on payment of Rs.120 P.A may also be kept in Regular Run for specified period.

(7) Record of ESIC-37 received, sent to the Branch Office for verification and when received back from Branch Office after verification, must be kept in the dispensary.

(8) MREs in Regular Run will have to be re-arranged at the beginning of new benefit period every time on receipt of fresh LIVE LISTS.

Action at Branch Office

13.2.32 (1) Manager must visit the dispensaries in his area and ensure that MREs of the insured persons shown in LIVE LISTS are re-arranged in Regular Run on receipt of LIVE LISTS every time.

(2) On receipt of ESIC-37, he must get them verified from RCs for relevant contribution period (if received at Branch Office) or from employer's record. Entitlement or non-entitlement must be informed to the dispensary.

(3) If the employer does not produce records for verification of ESIC-37, the IP may be treated as "Not entitled" and the dispensary may be informed accordingly.

(4) If found "Not entitled" on verification, ESIC-37 may be sent with suitable remarks to the Regional Office without any delay for taking prosecution and other actions against the employer. Suitable remarks may also be kept in the ledger sheet and declaration form of the IP for constant watch.

(5) All ESIC-37s verified from employer's record shall be sent to Regional Office for watching receipt of Returns of Contribution by concerned Revenue Branch there.

(6) Verification of ESIC-37 is unavoidable and must be done without delay.

(7) Proper record of verification in respect of ESIC-37 for a benefit period shall be kept and seen by inspecting officers during visit to a Branch Office. Inspecting Officer must put his signature in token of having seen the record in Branch Office.

Employer's compliance to be watched.

13.2.33 ESIC-37 cards will be of two types - (a) in which employer has certified re-employment/continuing in employment during the current contribution period and (b) where employer has

certified "has paid contributions for not less than half the number of days in the preceding contribution period". Separate pages will have to be maintained by both Regional Office and the designated Branch Office to watch compliance from employers towards submission of RCs in respect of these IPs.

13.2.34 In case of category (a) above, designated Branch Office/Regional Office has no option but to wait for the receipt of RC until after the end of the current contribution period. In cases falling under category (b) above, Regional Office will have to pursue the employer for submission of the return of contributions. As soon as the return is received, Regional Office/designated Branch Office will make entries in the register maintained by it .

Continued entitlement despite being debarred.

13.2.35 A reading of Section 56(3) of the Act reproduced in Para 13.2.2 *supra* would reveal that an IW who is qualified to claim maternity benefit as well as an IP who is in receipt of temporary disablement benefit, will be entitled to medical benefit. It follows that inspite of exclusion from Live List such persons (including members of their family) continue to be entitled to medical benefit upto and including the date on which:-

- a) duration of maternity benefit is exhausted, or
- b) the IP's temporary disablement is terminated.

13.2.36. Under the dispensary system, an exited insured woman on maternity benefit and an exited insured person on TDB in such circumstances will have no difficulty in continuing to receive medical care from the treating IMO if MRE with suitable remarks is kept in Regular Run. There is no need to call for ESIC-37 in such cases. However, under the panel system, the question of payment of capitation fee beyond the date of exit might arise. To prevent hardship to IW/IP in such circumstances, Manager of concerned Branch Office will send intimation in form ESIC-50 or ESIC-51, as the case may be, to the IMP with copies to the designated Branch Office and the AMO through Regional Office.

Exit of IP while under treatment

13.2.37 It may also happen that an insured person may be undergoing inpatient treatment in a hospital or receiving medical care and treatment at the time his name is dropped from current LIVE LIST and, therefore, he is debarred from medical benefit. In such a case, despite being debarred, he would continue to be entitled to medical care and treatment till the spell of sickness ends or, in the case of a long-term ailment, as long as he requires active treatment *vide* ESIC circular No.6-1/91/71(M)-II dated 3.1.1978 to all State Governments. Such an IP will also be entitled to the issue of medical certificates in the usual manner. Family members of the IP, however, will not be entitled to medical care in such a case from the date the IP is exited.

Entitlement of ESB cases to medical benefit

13.2.38 An insured person who qualifies for ESB is also entitled to medical benefit during an extended benefit period of 3 years as detailed in para 13.2.12 *supra*.

13.2.39 The entitlement position of an IP to extended medical benefit should be conveyed by Branch Office concerned in form ESIC – 48 to the Regional Office/designated Branch Office along with the return. Specimen may be seen at annexure-E & F to Chapter VIII-(P) - Extended Sickness Benefit Procedure. In addition, in service areas, a copy each of ESIC-48 alongwith the return will be sent by Branch Office concerned to Regional Office as well as to the IMO of concerned dispensary. In areas under panel system, 2 copies will be sent by the Branch Office concerned to the Regional Office who will, in turn, send one copy each to the AMO and IMP for necessary record and action. See also para P.8 .8 of Chapter VIII *ibid*.

13.2.40 Designated Branch Office/Regional Office maintaining ESIC-38 register shall record the period of entitlement in ESIC-38 register by writing the following words in **RED INK** across all the

contribution periods covered by the ESIC-48 over the signature of the Branch Manager/Officer In charge in case of RO :-

“ESB Case – entitled upto

At the time of opening of new register (ESIC-38), care will be taken to continue all such cases upto the date mentioned in the old register by recording the above mentioned remarks in the new register for the remaining period, again in **RED INK** over signature of the Manager/Section Superintendent. IMO/IMP, on receipt of ESIC-48, will make an entry on the MRE of the IP.

“ESB Case – entitled to medical benefit upto

He will sign with date below this entry.

Family’s entitlement in ESB cases

13.2.41 Except in cases falling under para 13.2.37, the family of an IP who is found entitled to receive ESB for a long-term disease, will also be entitled to medical benefit for the same period as he himself. In the event of death of such an IP, his family would continue to be entitled to medical benefit upto the end of the period for which IP himself would have been entitled, had he survived.

Opening of new registers

13.2.42 At the time of opening new ESIC-38 registers after the old registers are exhausted, those Ins.Nos. against which nothing was entered in the immediately preceding 6 or more consecutive contribution periods (after being exited) will not be carried forward in the new register. Any odd insurance number that may come up again after its absence for the said period may be accommodated at its proper place by inserting it in serial order. For this insertion, a straight line may be neatly drawn in between the preceding insurance number and the next following so as to make entries for the current as well as succeeding contribution periods.

Indelible ink for entries in ESIC-38 registers

13.2.43 Entries in ESIC-38 registers should be made in indelible ink or by ball-point pen using blue-black or black ink. Entries required to be made in RED INK should invariably with red ball-point pen.

Test check of entries and of cancellations

13.2.44 Every ESIC-38 register should be provided with a fly-leaf which should be divided in two parts by drawing a vertical line in its middle. The two columns thus made out should have the headings ‘Test Check of entries’ and ‘Test check of cancellations’ respectively. The following percentage test check of entries as well as of cancellations will be conducted in every ESIC-38 register:-

2% of entries - By Head clerk or , if he has originally attested, by the BM
2% of cancellations

1% of entries - By BM/visiting Dy./Jt.Regional Director.
1% of cancellations

Further, test check of entries by Head Clerk/BM/Branch Officer (in respect of work going on in Regional Office) should be done in such a way as to cover every ESIC-38 register in a year.

Certificate of completion of work

13.2.45. Manager of designated Branch Office and Regional Director in Regional Office (where entitlement procedure will continue as hitherto) should personally monitor the work on weekly basis immediately after the end of each CP till 15th of June and 15th of December every year. The Manager of designated Branch Office should submit a certificate to Regional Office by 30th June and 31st December, every year, certifying the issue of exit and re-entry lists and Regional office will like-wise send a certificate for the whole region to Hqrs. Office by 15th of July/January every year.

Follow up action at Branch Office

13.2.46 Every Branch Office should arrange to have sufficient imprest for meeting the cost of additional expenditure on postage, etc. Also, the following rubber stamps should be procured by every Branch Office for use in connection with the work :-

i) LATE - Suggested size : 1 ½” x 2”

ii) Date stamp/dater

iii) Receipt of RC acknowledged subject to verification

Manager
Branch Office _____,

iv) Exit and Re-entry stamps.

Supply of blank forms

13.2.47 Regional Office will take care to supply copies of blank forms of ESIC-37 and ESIC-166/166A to each dispensary. Under panel system, the blank forms will be supplied to the AMO who will distribute a few forms to each IMP. Sufficient stocks should also be kept at each Branch Office for supply to needy IPs.

PART-III Super-Speciality Treatment – Restrictions on

Standing Committee Resolution dated 23.06.2003

13.3.1 With a view to preventing misuse of medical facilities under the ESI Scheme, the Standing Committee, at its meeting held on 23.06.2003, resolved that IPs and their family members (other than those injured in an accident) would be entitled to super – speciality medical care including cost of medicines only if they become eligible for sickness benefit. The Standing Committee, however, indicated that genuine cases should not be allowed to suffer and the restrictions being imposed may be relaxed in deserving cases by the Director General. Powers for relaxation have been further delegated to Senior State Medical Commissioner/State Medical Commissioner. Super-speciality treatment has been defined as costly medical treatment and procedures in institutions other than ESI hospitals and dispensaries.

13.3.2 In this context, the meaning of ‘accident’ appearing in the preceding para is restricted to an accident arising out of and in the course of employment. The Standing Committee Resolution does not affect the right to super-speciality treatment of a person who, as an ‘employee’ as defined in the ESI Act, sustains a personal injury caused by an accident arising out of and during the course of employment. Thus, to be entitled to super-speciality treatment, the condition of eligibility to sickness benefit is not applicable to those persons who are in receipt of temporary disablement. This is also duly confirmed by section 56 (3) of the Act, vide paras 13.2.2 and 13.2.35 supra.

Who qualifies for super-speciality treatment ?

13.3.3 Keeping in view the provisions of the Act and the foregoing Standing Committee's Resolution, the IPs who fall in one or other of the following groups will be eligible to super-speciality treatment:

- i) Those qualifying for sickness benefit, during the benefit period.
- ii) Those in receipt of TDB, so long as it lasts.
- iii) As per section 56(3), an IW is entitled to medical benefit if she is qualified to claim maternity benefit.

The families of the above-named insured persons/insured women would also be entitled to medical benefit including super-speciality treatment during the period they themselves are eligible.

Relaxation of Standing Committee Resolution

13.3.4 In respect of persons who do not fulfill any of the above conditions for super-speciality treatment, the Director General has agreed to relax the Standing Committee's Resolution on the subject if one of the following conditions is satisfied:

- i) The IP was eligible for the sickness benefit in the immediately preceding benefit period
Or
- ii) The IP was employed as an 'employee' as defined in the ESI Act during four consecutive contribution periods immediately preceding the benefit period in which super-speciality treatment is to be availed by him or his family under the ESI scheme and at least 156 days' contribution has been paid by the IP during the said four contribution periods with eligibility to sickness benefit in at least one of them.

In addition, the IP should also be entitled to medical benefit during the current benefit period. Cases of this nature were being referred to Hqrs. for relaxation by the Director General. However, vide Hqrs. letter No. N-11/12/1/96-Bft.-II (Instruction No. 05/2007), dated 08.10.2007, the Director General has, with a view to cut down delays, delegated his powers of relaxation to every Regional Director/Jt. Director (i/c). For other cases of genuine/deserving nature which do not satisfy the above conditions, the Director General has delegated the powers of relaxation to the SSMC or SMC in the regions vide Hqrs. Circular No. N-11/12/1/2008-Bft.II dated 05.11.2008.

Persons not eligible to super-speciality treatment

13.3.5 Provisions of super-speciality treatment are totally out of scope for the following categories of protected person:-

- i) Superannuated and permanently disabled persons to whom medical care is provided by the ESI Scheme under Rules 60, 61 of ESI (Central) Rules, 1950.
- ii) Persons in receipt of unemployment allowance.

Treatment to continue for those excluded from Live List

13.3.6 Attention is invited to para 13.2.37 supra which describes inter-alia that an insured person under medical treatment whose name is excluded from the Live List at the start of a benefit period, if suffering from a long-term ailment should be allowed to continue availing treatment as long as he requires active treatment.

13.3.7 The decision to continue super-speciality treatment to a person suffering from a long-term disease for so long as he needs 'active' treatment was taken by the Corporation on humanitarian grounds. But, such a relaxation was found to have been misused by certain persons whose disease was of such a nature that it needed 'active' medical treatment for an indefinite period long after those persons were exited

from medical treatment. To prevent misuse of this humanitarian facility, the Corporation, on the advice of its medical experts, resolved at its meeting held on 06.09.2002 that the super-speciality medical treatment would be admissible only to those patients whose disease was curable, so long as they needed 'active' medical treatment. Further, those IPs who were suffering from such diseases which were incurable would also be allowed treatment as long as their disease was in 'acute' form and as soon as the disease reached the stage when the condition of the patient was stabilized, super-speciality treatment would be terminated.

Relaxation

13.3.8 In the light of foregoing instructions on the subject, Branch Managers should refer cases of those IPs who need super – speciality treatment but do not satisfy the contributory condition, to the Regional Office for submission with full details to SSMC/SMC in the proforma at annexure VII for relaxation.

Availing super-speciality treatment

13.3.9 Branch Managers are often approached for guidance by insured persons who, for the treatment of their ailment, have been referred to a super-speciality hospital but are totally ignorant about the formalities to be gone through and the hospital referred may be at a place unknown to them. Managers can offer guidance to them based on the following instructions issued by Head quarters:

1. The Director General has approved that the insured persons and their family members can avail of super-speciality treatment from any of the network / tie-up hospital of ESIC all over the country.
2. Patient will be free to select any of the network/tie-up hospital of his /her choice in the same state or any other state for getting the required super-speciality treatment. Managers are advised to keep the list of such hospitals which is available on computer website www.esic.nic.in with them. Alternatively, it may be obtained from the Regional Office and kept up to date.
3. Reference to the network/tie-up hospital shall be made by the respective authorised ESI hospital/dispensary, as per list already communicated by Head quarters office vide letter No. V-24/11/10/2004-Med.I dated 23^{re} July, 2008 and 22nd August,2008 and 15th January,2010. A copy may be obtained from the Regional Office if not already with the Manager.
4. The referring hospital/dispensary shall send a copy of the reference slip to the SSMC/SMC of the referring and the referred state from where the patient wants to get the required super-speciality treatment.
5. SSMC/SMC of the state, from where the patient wants to take treatment, shall intimate the network/tie-up hospital for providing necessary/required treatment and send the bills for payment to the SSMC/SMC of the state from where he was referred, after the treatment is over.
6. SSMC/SMC shall make the payment within three working days to the tie-up hospital (s) with intimation to the concerned State SSMC/SMC and referring hospital/dispensary as the case may be.
7. The expenditure in all such cases is to be totally borne by the ESI Corporation.
8. **No TA/DA shall be payable to the patient and their family members in all those cases where the patients themselves have decided to go to other state for getting the treatment.**

BRANCH OFFICE _____
Employees' State Insurance Corporation

No.

Dated: _____

To

The Regional Director
Cash Contribution Section,
Regional Office,
E.S.I. Corporation,
_____.

Sir,

Please find enclosed first copies of the following RCs received in this office for necessary action in the Regional Office as per procedure.

Kindly send acknowledgement on the duplicate copy of this letter.

Sl.No.	Code No. of employer.	No. of Challans.

Yours faithfully

MANAGER

Encl: as above

Receipt acknowledged.

(Branch Officer, CC Section, RO)

BRANCH OFFICE _____
Employees' State Insurance Corporation

No. _____ Dated:- _____

To
 The Manager, Branch Office,
 E.S.I. Corporation,
 _____.

Sir,
 Please find enclosed 2nd copies of the following RCs for necessary action.

Kindly send acknowledgement on the duplicate copy of this letter.

S.No.	Code number of employer	No. of challans	S.No.	Code number of employer	No. of challans

Yours faithfully,

MANAGER

Encl.: as above

Receipt acknowledged.

Manager, Branch Office,

ANNEXURE- III
 (See Para 13.1.5)

BRANCH OFFICE _____
Employees' State Insurance Corporation

Watch-over register of RCs received from employers attached to this Branch Office

Employer's Name & Address	Code No.	Date of receipt of RC for CP ending				
		9/06	3/07	9/07	3/08	9/08.....
ABC LTD	21-001-11	6.11.06	5.5.07			
XYZ LTD	21-051-66	2.11.06	4.7.07 CCP*			
KLM CO.	21-111-83	10.11.06	10.5.07			
Etc.	etc.	etc.				

*All such entries should be made in red ink.

Reminder

**BRANCH OFFICE _____
EMPLOYEES' STATE INSURANCE CORPORATION**

No.

Date:

To

M/s _____

Subject : Non-submission of return of contributions for contribution
period ending _____.

Sir,

I have to inform you that the return of contributions under Regulation 26 or certificate of contributions payable under Regulation 27 for the contribution period ended _____ which was due from your factory/establishment latest by _____, has not so far been received from you. Non-submission of RC is an offence under the ESI Act, 1948 and regulations made thereunder. Besides, your employees will be unjustly debarred from medical and cash benefits resulting in hardship to them. You will also be faced with a spate of enquiries from this office as well as from your employees. You are, therefore, requested to submit the relevant RC in quadruplicate to this office without any further delay.

2. However, in case you are facing any difficulty in submitting the return, please submit [in lieu of the RC for the time being], a certificate of contributions payable in respect of your covered employees. This certificate should mention all the particulars required in page 2 of the RC and it should also be submitted in quadruplicate. This certificate will enable your employees to avail of all the benefits under the Scheme.
3. Meanwhile, you can arrange to submit the RC as soon as possible so as to avoid any unpleasant steps against you in the shape of prosecution action etc.

Yours faithfully,

()
BRANCH MANAGER

ESIC-38

REGISTER UNDER REGULATION 103-A

Insurance Number	Date of entry	Name of Dispy.	CONTRIBUTION PERIOD							
			From	From	From	From	From	From	From	From
			To	To	To	To	To	To	To	To

BRANCH OFFICE _____
EMPLOYEES STATE INSURANCE CORPORATION

To
The IMO Incharge
E.S.I. Dispensary

To
The AMO*
E.S.I. Scheme

Sub.: Entitlement for Medical benefit under the E.S.I. Scheme - Live
List.(Main/Supplementary)

Sir,

The I.Ps whose Ins.Numbers are given below alongwith their families, are entitled to medical benefit for the benefit period from ____to____. It is requested that medical benefit may be made available to each IP as well as to his/her family w.e.f. aforesaid date unless otherwise notified.

Sl.No.	Ins.No.	Sl.No.	Ins.No.

* The medical acceptance cards of above IPs may please be kept in regular run and the IMPs may be informed accordingly.

Kindly acknowledge receipt.

Yours faithfully,

Manager

* Applicable in case of panel system only.

**PROFORMA FOR RELAXATION IN CONDITION FOR
SUPER-SPECIALITY TREATMENT**

1. Region _____ 2. Branch Office _____
3. Dispensary/hospital to which IP attached _____
4. Name of the IP _____ 5. Insurance No. _____
Employer's Code No. _____
6. Name of the person needing super-speciality Name _____
Treatment and relationship with IP (as verified from DF) Relationship _____
7. Date of entry into insurable employment with the above – named employer if eligibility is based on previous insurable, please indicate the same
.....
8. Date from which and benefit period in which super speciality treatment is to be taken
Date _____ Benefit Period _____
9. Name of Hospital where super-speciality treatment is proposed to be taken _____
_____.
10. Whether the treatment for which relaxation is sought comes under
“super - speciality” category _____
11. Name of disease / diagnosis _____
12. Details of contributions paid during immediately preceding four contribution periods:
- | Contribution periods | | Days for which contribution paid |
|----------------------|----------|----------------------------------|
| | | (Form - 6) |
| a) _____ | To _____ | _____ Days |
| b) _____ | To _____ | _____ Days |
| c) _____ | To _____ | _____ Days |
| d) _____ | To _____ | _____ Days |
13. Benefit period for which relaxation is sought _____
14. Is IP entitled to medical benefit during benefit period for which relaxation is sought _____
15. Is the case fit for relaxation as per Hqrs. Letter dated 29/11/04 _____
16. Regional Office recommendation

Signature of Branch officer

SSMC/SMC

CHAPTER – XIV

FINANCE & ACCOUNTS OF A BRANCH OFFICE

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PART – V – Branch Manager's Role as Member of Hospital Development Committee

CHAPTER-XIV

FINANCE & ACCOUNTS OF A BRANCH OFFICE

The Source

14.1.1 The instructions contained in this Chapter describe the procedure for all types of financial transactions carried on in a Branch Office as well as maintenance of records pertaining to them, their classification, etc. **These have been extracted from the Manual of Audit & Accounts of the Corporation** - Third Edition - as modified from time to time by the subsequent issue of instructions from Headquarters Office.

Financial Transactions at a Branch Office

14.1.2 Normally, the following transactions take place in a Branch Office of the Corporation and for each of them a separate cash book is maintained in the Branch Office :-

- (1) Transactions of moneys received in ESI Fund Account No.1, recorded in cash book Account No.1.
- (2) Transactions of payments made from ESI Savings Fund Account No.2 of the Branch Office, recorded in cash book Account No.2 of the Branch Office.
- (3) Transactions of pay and allowances of staff and of contingent expenditure, recorded in the imprest cash book.
- (4) Hospital Development Committee – Opening of accounts and its maintenance procedure is to be followed as per instruction No. U-16/18/1/6/2007-Med I dated 24.07.08 at Annexure 'H' enclosed.

Detailed instructions on maintenance of cash books may please be seen in para 14.4.3 below.

14.1.3 The first type of transactions represents receipts of the Corporation. **However, a Branch Office transacts in receipts of a minor nature only, such as the following:-**

- (i) Price of duplicate identity cards.
- (ii) Recoveries of excess payments erroneously made by Branch Office or wrongfully received by insured persons.
- (iii) Refund of overpayments, balances in r/o various advances and other Corporation dues from its employees.

Also, occasionally, the following transactions are recorded in this cash book:-

- a) Amount received for availing medical benefit by disabled or superannuated employees of covered factories/ estts. under Central Rules 60, 61.
- b) Amount received as a result of court orders, etc.
- c) Amount received from auction and sale proceeds of condemned articles.
- d) Application fee and other charges received under RTI Act.

14.1.4 The second type of transactions, viz., in ESI Savings Fund A/c No. 2 of the Branch Office, are of a major nature because the Branch Office has its main objective of disbursing cash benefits to insured persons out of the funds made available to it in its ESI Savings Fund A/c No.2.

14.1.5 As for the third type, moneys received from Regional Office (a) towards recoupment of permanent imprest, (b) for contingent expenditure incurred on the upkeep and maintenance of the branch office and (c) as temporary advance etc., to meet any exceptional expenditure of a miscellaneous nature, are recorded in a separate cash book known as imprest cash book. At places where ECS facility is not

available, moneys received from A/c No.2 of the Branch Office towards salaries as well as disbursement of these salaries to officers and staff posted at the Branch Office, are also recorded in this cash book.

Part I -Transactions in A/c No.1 (Receipts)

Receipts & Receipt Books

14.1.6 For every transaction in A/c No.1, in which money may be received in cash at the Branch Office, a receipt is to be issued to the tenderer. For this purpose, a receipt book containing 100 blank receipt forms will be supplied by the Regional Office to the Branch Office. The form of the receipt book is as per form-1 to the ESI (Central) Rules, 1950. Every receipt book when received should be examined to see that (i) it is intact in every respect and (ii) no receipt or counterfoil is missing from it. A certificate should be recorded and signed by the Branch Manager on the inner cover before the first receipt, to the effect that the receipts have been counted and found to be 100 in number. He should also cause his office stamp affixed on each receipt folio and counterfoil contained in the receipt book. Every such receipt book shall also be entered in the register of receipt books in form A-5. But, only one receipt book should be put into use and should continue to be used until exhausted. The receipt book currently in use, the blank receipt books as well as the register shall remain in the personal custody of the Branch Manager. Specimen of this register in form A-5 is given below:-

Form A-5

Stock Register of Receipt Books

Date	Regional Office Reference No.	Description of printed receipt books received	Dated initials of Branch Manager	Date of putting into use	Initials of Branch Manager	Remarks

14.1.7 Whenever any amount receivable in the Branch Office is received, it shall be immediately and without any reservation, brought to account in the Branch Office cash book A/c No.1. This cash book shall be in form A-11A and it shall be securely bound and its pages machine-numbered. A receipt from the receipt book shall be prepared by the Cashier showing the amount received written both in figures and in words in it. If the amount received exceeds Rs.5000/-, a revenue stamp shall be affixed on it and it shall be handed over to the tenderer after getting it signed by the Branch Manager. The cost of the revenue stamp shall be charged to contingencies and met out of imprest of Branch Office.

14.1.8 In case of Grade-I Branch Office where both Manager Gr.-I and Deputy Manager are posted, the receipt in form-1 may be signed by the Deputy Manager subject to Manager Gr.-I continuing to exercise overall authority and being responsible for incorporating all such transactions daily in the cash book A/c No.1.

14.1.9 In the absence of Branch Manager on casual leave, etc., and there being no Dy. Manager, the Head Clerk and, where no Head Clerk is posted, Cashier/Upper Division Clerk may receive money and issue provisional receipt, to be followed by the issue of regular receipt on Branch Manager's return. Printed provisional receipt book will be supplied by the Regional Office.

Transactions in Account No.1 at a Pay Office

14.1.10 Insured persons employed in factories/estts. covered under the Act but situated at a remote place, find it very difficult to visit the Branch Office to which their factory/estt. is attached. At the same time, the number of cash benefits at such a place does not justify the setting up of a full-fledged Branch Office. For the convenience of such persons, a 'Pay Office' is set up generally in one of the ESI dispensaries locally situated and the Cashier of the parent Branch Office visits the Pay Office once or twice a week to (i) collect medical certificates issued to IPs as well as their claims for cash benefits, (ii) to make payment of cash

benefits on certificates collected during his previous visit or received by post and (iii) to collect applications for duplicate identity cards, etc.

14.1.11 For the last mentioned purpose, the Cashier collects the applications alongwith the fees, fills up and signs a receipt in triplicate from the provisional receipt book held by him, in respect of each application and hands over one foil to the applicant IP. The provisional receipt enables the IP to claim medical benefit for himself and his family. When he goes back to the parent Branch Office, he deposits the fee collected into the Branch Office Account No.1 cash and prepares a regular receipt from the receipt book at the Branch Office and gets it signed by the Manager. Each regular receipt thus issued will contain the legend on its top, "This cancels the provisional receipt No. issued on". The Cashier gets the duplicate identity cards prepared and, on his next visit to the Pay Office, hands over the DICs as well as the regular receipts to the concerned IPs.

No Receipt Other Than Under Rules

14.1.12 It is to be noted that the issue of a receipt for money received by a functionary of the Corporation, otherwise than in accordance with the rules on the subject as detailed herein, is strictly prohibited and shall be treated as a serious offence calling for severe disciplinary action. The only exception to this would be the money received in a Court case by Manager / Inspector as explained in paras 14.1.14(b) and 14.1.16 as well as those given in paras 14.1.17 and & 14.1.18 below.

Cash Book A/c No.1.

14.1.13 It will be the duty of the Manager/Deputy Manager signing the receipt to check that money received has been duly recorded in the cash book A/c. No.1 and in token of this check, to attest the entries in the said cash book. Cash book Account No. 1 shall be operated as well as closed on the same day as on which a transaction takes place.

Receipt of Dues in Court Case

14.1.14 A Branch Manager has no authority to receive cash/cheques/demand draft from any employer as contributions due unless specifically permitted in any case to do so. However, at outstations where Branch Manager may have to pursue cases at the local E.I. court, an employer may pay ESIC dues on the spot in the court itself, in cash or by cheque/demand draft. Such a payment shall be dealt with as under:

- (a) **Cash received:** Branch Manager may issue a formal receipt in form-1 to the employer and take immediate steps to deposit the money in the bank to the credit of Branch Office A/c No.1. The transactions of receipt and payment will also be recorded in the account No.1 cash book of Branch Office. Branch Manager will also inform Regional Office about this transaction with full particulars.
- (b) **Cheque/draft received:** The cheque/demand draft if crossed, 'Account Payee', and payable to ESI Fund A/c No.1 of Regional Office may be accepted and only an acknowledgement of receipt of the cheque/demand draft should be signed and issued by the Branch Manager to the paying party. The cheque/demand draft should be deposited immediately in the bank to the credit of Regional Office A/c No.1. Such a cheque/demand draft shall not be entered in Branch Office cash book A/c No.1. Full particulars of the cheque/demand draft should be furnished by Branch Manager to Regional Office (Finance Branch) who would issue a formal receipt to the paying party on receipt of credit of the amount of cheque/demand draft in A/c No.1 of Regional Office.

14.1.15 In a rare case, an ESI Inspector, having received an amount in cash against a decree in a court, may not find it possible to deposit it the same day in the bank. It may also happen that ESIC's Recovery Officer on tour at an outstation may recover some amount from a defaulter employer but it is not possible to deposit the amount in the bank. In both cases, the amount so recovered will be handed over with a letter

providing full details at the nearest Branch Office whose Manager would give an acknowledgement which may either be by signing a register maintained by the Recovery Officer or the Inspector, or on plain paper. No printed receipt will be issued. The transaction will pass through cash book A/c No.1 of the Branch Office.

14.1.16 The Branch Manager will deposit the amount in accordance with the procedure explained in para 14.1.14(a) above through a separate challan and send intimation to Regional Office and the Inspector. He will keep the depositor's copy of the challan in his safe custody.

Amount Received by Money Order

14.1.17. If any amount receivable/refund, etc., is received by money order, the postal receipt shall be signed only by the Manager himself who will also cause an entry of the amount being made simultaneously in the cash book A/c No.1 under his own initials and hand over the postal coupon and the cash to the Cashier.

Benefit Money Orders Received Back Undelivered

14.1.18. Money orders of benefit payments sent by Branch Office are sometimes received back undelivered. Amount of such money orders will not be deposited in A/c. No. 1 but taken as a credit in cash book A/c. No. 2 of Branch Office. No formal receipt is to be issued.

Deposit of Amounts Received into Bank

14.1.19 The amounts received by the Branch Office in Account No.1 during the course of its functioning should be deposited in the bank by means of a challan in form S-III or S-VII in triplicate to the credit of A/c No.1 of Regional Office on the last working day of each month, or earlier if such amount reaches the limit of Rs.1000/-. However, if a Branch Office is located more than 8 KMs away from the bank branch, the amount in A/c No.1 may be deposited only as and when Cashier goes to the bank or whenever the balance in hand reaches the limit of Rs.1000/-. Condition of compulsory deposit of the balance on the last working day does not apply in case of such a Branch Office.

14.1.20 The bank branch will also accept amounts paid by the ESI Branch Manager as well as cash/cheques/demand drafts deposited by employers of the area towards payment of contributions, etc. by means of challans in quadruplicate, two copies of which, duly receipted, will be returned to the tenderer. Full details of these receipts will be forwarded to Regional Office alongwith a copy each of challans as well as two pen-carbon copies of the day book, accompanied by a demand draft for the amounts received in whole thousands the same day or latest by the next working day.

Monthly Return to Regional Office

14.1.21 The details of transactions recorded in a month should be prepared in form A-18 and forwarded to Regional Office by the 2nd of the month following that to which it relates. On receipt of the account, the Fin. & Accounts Branch at Regional Office will trace the deposits made by the Branch Office in the cash book Account No.1 maintained at the Regional Office. Discrepancies, if any, shall be settled by correspondence with the bank and / or the ESI Branch Office.

Part II -Transactions in Account No. 2 (Payments)

Banking Arrangements – General

14.2.1 All expenditure under the ESI Scheme, including expenditure on provision of benefits to insured persons and their families, salaries and allowances of officers and staff of the Corporation, upkeep and maintenance of buildings and property owned by it, running of offices of the Corporation, etc., is met out of ESI Fund Account No. 2 to which transfers are made from ESI Fund Account No. 1 by the authorised officers of the Corporation. For providing cash benefits to insured persons as well as to take care of their needs, the Corporation has set up a large number of Branch Offices all over the country. Every such office has a separate ESI Savings Fund Account No. 2 at a local branch of the State Bank of India. In certain States/areas, such accounts have been opened with the branches of some nationalised banks. The banking arrangements with these banks are more or less similar to those with the State Bank of India.

Opening of Bank Account of Branch Office

14.2.2 (a) Whenever a new Branch Office is set up by the Corporation, an Account No. 2 of such an office under the name and style of "Employees' State Insurance Savings Fund Account No. 2 _____ Branch Office" has to be opened. Regional Office obtains consent of controlling office of SBI branch where SB A/c No.2 is proposed to be opened and send the same to the F&A division as Hqrs. Office alongwith the duly attested signature of present incumbent of the post of Branch Manager in a prescribed proforma duly filled in. Thereafter, a letter is addressed by Financial Commissioner/Director (Finance)/Joint Director (Finance) to State Bank of India, New Delhi, Main Branch, giving the name of the bank branch, details of the account to be opened, the terms and conditions for operation of the account, name of the office, name of the present incumbent of the post of Branch Manager(alongwith the attested signature of branch manager), and the daily and monthly limits of withdrawal for the branch office. A TA note for a token amount, usually of Rs.1000/-, is also enclosed with this letter. The ESI Branch Manager will keep in touch with the local SBI branch and, as soon as the account is opened, he will collect a cheque book containing 100 order' cheques from the bank branch. The account thus opened will normally be operated by the ESI Branch Manager subject to the withdrawal limits in force from time to time. Subsequent changes in the incumbency of the Branch Manager would be intimated in writing by the Regional Director/Dy. Director (Finance) to the bank branch holding Account No. 2 of the ESI Branch Office. However, specimen signatures of the new Manager will be attested by the outgoing Manager and forwarded direct to the bank branch holding ESI Savings Fund Account No. 2 of the ESI Branch Office.

(b) A copy of the banking arrangements made with the local bank branch will invariably be endorsed to the concerned ESI Branch Manager. The local bank branch will also send him the advice for the credit of the token amount transferred by the Hqrs. to the Savings Bank A/c No.2 of his Branch Office. However, if the copy of the banking arrangements is not received by the time the credit advice is received, he should obtain a copy from Regional Office, keep it in his record and ensure that all its terms and conditions are strictly observed.

(c) According to the terms and conditions in the said arrangements, the concerned bank branch has to issue demand drafts at applicable charges (as per agreement) at the written request of the ESI Branch Manager against cheques drawn by him on ESI Savings Fund A/c No.2 of his Branch Office.

(d) The bank branch will accept and keep in safe custody a packet containing the duplicate keys of the safe and cash boxes of the ESI Branch Office. These service would be provided by the bank free of charge.

Operation of ESI Savings Fund Account No. 2

14.2.3 The following procedure shall be followed by the ESI Branch Manager for operation of A/C No.2.

(1) The base bank branch having the ESI Savings Fund Account No. 2 of an ESI Branch Office shall credit on the first working day of every month to ESI Savings Fund Account No. 2 of the Branch Office, a sum equal to its monthly withdrawal limit with a simultaneous debit of an equivalent

- sum to the bank's ESI Savings Account No.2 of the Regional Office maintained at other SBI branch called link branch. ESI savings fund A/C No. 2 of Regional Office/Sub Regional Office at link branch received automatic credit (on Ist working day of the month) of an amount equal to monthly limit of all branch Office under its jurisdiction. This credit is afforded directly by SBI New Delhi main branch maintaining ESI savings fund A/C No. I(central).
- (2) The concerned base branch of the bank will send a credit note of the sum credited to the ESI Branch Manager with a copy of the same to the Regional Office. The ESI Branch Manager will take the credit of the amount into the bank column of cash book of Account No. 2 of the Branch Office. He will also ensure every month that the amount is credited to Savings Fund A/cs. No.2 of his Branch Office on the due date.
 - (3) The ESI Branch Manager will go on drawing funds from the said bank account subject to his daily and monthly limits. It is to be noted that these limits are applicable with reference to date of the issue of the cheques and not the date of presentation at the bank counter. Further, these limits are not applicable to the following operations on this account:
 - (i) Amounts of 'account payee' cheques issued by the ESI Branch Manager to IPs towards payment of cash benefits.
 - (ii) Transfer of funds from ESI Savings Fund Account No. 2 of the Branch Office to another account of the Corporation.
 - (iii) Cash withdrawn for payment of salaries and other dues to the officers and staff at the Branch Office as well as payment of pensions to retired employees of ESIC (applicable only at places where ECS facility is not available).
 - (iv) Amount drawn by Branch Manager on the strength of payment slip received from Deputy Director (Fin.) towards contingent expenditure incurred directly by the Branch Office.
 - (4) If, on occasions, ESI Branch Manager falls short of funds or his commitments exceed the funds available, he can ask for more funds from the Dy. Director (Finance) at Regional Office. If the Regional Office is at the same station as the Branch Office, the Dy. Director (Finance) will send a cheque from Regional Office Account No. 2 for the required amount in favour of the Branch Manager. However, if the Regional Office is at a different station, the Dy. Director (Finance) will obtain a demand draft and send it to the Manager. In either case, a payment slip, in duplicate, duly signed by the Dy. Director (Finance), will accompany the cheque+/demand draft/Core Banking System. ESI Branch Manager will deposit the cheque/ demand draft in the bank alongwith the payment slip in his Account No. 2 and the bank branch will allow the ESI Branch Manager to draw funds on the same day without waiting for the credit of the amount from the branch on which the cheque is drawn. The withdrawal limit of the ESI Branch Manager against such a cheque/demand draft will not be applicable.
 - (5) Monthly withdrawal limit of every Branch Office is fixed keeping in view the trend of benefit payments plus the amount required for and other recurring expenditure, e.g., rent of building, telephone and electricity bills and, where required, monthly disbursement of salaries of officers and staff and payment of pension, etc. Daily limit is arrived at keeping in view the trend of expenditure likely to be incurred on benefits paid in cash at the Branch Office in 2 or 3 days of its working. The daily limit of cash drawal is to be exclusive of any payments made by 'Account Payee' cheques and care must be taken to draw only that much cash which is likely to be disbursed within 2 or 3 days including the date of drawal. Further, cash should be withdrawn in such a way as to leave very little in the chest just before weekly or other holiday(s).
 - (6) The monthly and daily limits are fixed and reviewed by Hqrs. only in the months of January and July each year. Shortages of funds occurring in the meantime can be met in the manner provided in sub-para (4) above. Any Branch Manager requiring a revision of these limits should approach

the Regional Office by the end of December and June, giving full justifications based on actual expenditure (inclusive of expenditure on salaries and allowances paid to officers and staff for whom Branch Manager is the Drawing & Disbursing Officer (DDO) and other recurring expenditure, etc.) for the past 6 months and keeping in view other factors such as increase in PDB/DB rates etc. However, a newly set up Branch Office may approach for revision for the first time even earlier than the end of June and December, as the case may be.

- (7) On the last working day of every month, the Branch Manager should review the position of cash in his Savings Fund Account No. 2 in the bank and, after retaining a balance of less than Rs. 1,000/- in his bank account, deposit an amount in multiples of Rs. 1,000/- into ESI Fund Account No. 1 of his Regional Office through 'Account Payee' cheque supported by challan in quadruplicate, on the first working day of next month. Two copies of the challan will be returned by the bank. As stated in item (ii) of sub-para (3) above, restrictions on withdrawal limits by the Branch Manager will not apply in this case.
- (8) The Branch Manager will send an intimation of such transfer to the Dy. Director (Fin.) by name on the same day alongwith a copy of the challan as well as information about balance left in the bank account. Any laxity on his part will be viewed seriously and reported by the Dy. Director (Fin.) to the Regional Director as well as to the Hqrs. Office.
- (9) Interest on balances in the ESI Savings Fund Account No. 2 of the Branch Office with the bank will be credited by the bank to this account on due date as per savings bank rules and the ESI Branch Manager, on receipt of intimation from the bank, shall give credit of this interest in his cash book Account No. 2. The correctness of the interest credited by the bank should be checked and intimation thereof may be given to Deputy Director (Fin.). The interest thus received should be deposited in Regional Office Account No.1.
- (10) A detailed statement of receipts and payments in Account No. 2 of the Branch Office alongwith opening and closing balances for a calendar month will be furnished by the bank branch holding Account No. 2 to the Manager of ESI Branch Office, with a copy to Regional Office so as to reach by 10th of the month following the month under report.
- (11) On receipt of the said statement in the Branch Office, the entries made therein shall be checked item by item with the cash book Account No. 2 and errors, if any, noticed therein shall be brought immediately to the notice of the bank branch for rectification. The bank balance shown in the ESI Branch Office Account No.2 at the end of the month shall be reconciled with the balance shown in the monthly statement rendered by the bank, in the following manner:-

STATEMENT OF RECONCILIATION WITH BANK BALANCE

Amount (Rs.)

Closing balance as per bank column of the cash book

ADD amount of cheques issued but not cashed by the bank (Details at 'A' below)

ADD credits accounted for by the Bank but not included in the Corporation accounts pending receipt of advice (Details at 'B' below)

Total:

DEDUCT debits raised by the bank but not passed in the Corporation accounts pending receipt of advice/particulars (Details at 'C' below)

Closing balance as per bank statement =
 Details of 'A' =
 Details of 'B' =
 Details of 'C' =

Date _____ Signature.....

The ESI Branch Manager will submit the reconciliation statement described above to the Dy. Director (Finance) at Regional Office so as to reach him by 15th of the month following the one to which it relates.

NOTE :- Reconciliation of balance in the bank column of the Branch Office cash book A/c. No. 2 with the bank balance as shown in the bank statement and follow up action thereon, if any, is of utmost importance inasmuch as it reflects the true state of affairs both in the bank account and in the Branch Office account. Branch Manager should, therefore, be watchful about receipt of the bank statement and should get the reconciliation done under his direct supervision at the earliest and personally check and sign it invariably every month. Further, the said reconciliation being a part of the cash book A/c. No. 2 which is a permanent record of the Branch Office, the said statement should be recorded in cash book A/c. No. 2 itself of the Branch Office. For this, sufficient space should be left below the last working day's entries, so as to accommodate the reconciliation statement when the bank return is received *vide* sub-para (10) above.

Cheques and Cheque Books

14.2.4 As mentioned in Para 14.2.2(a) above, the first cheque book containing 100 order' cheques will be supplied by the bank branch at the time of opening of ESI Savings Fund Account No.2 of the Branch Office. This cheque book shall, as soon as received, be carefully examined by the Branch Manager who should count the number of forms contained in it and record and sign the following certificate in the flyleaf:

"Certified that I have this day the _____ counted the cheques in this book and found them to be _____ in number.

Manager"

He will also enter the cheque book in the stock register of cheque books in form A-4 as per specimen below and initial the entries in columns 4, 5 and 6 of the register.

Stock Register of Cheque Books

Sl.No.	Ref. to requisition made to the bank for cheque book	Reference to bank's letter providing the cheque book	Particulars of cheques received: Book No. & Sl.Nos. of cheque forms	Date from which cheque book brought into use	Date on which cheque book is exhausted	Remarks
1	2	3	4	5	6	7

14.2.5 Subsequent supplies of cheque books will be made by the bank only on receipt of printed requisition form which is inserted in each cheque book towards the end and never more than one cheque book on a single requisition, to be signed by the ESI Branch Manager over his official rubber stamp. Branch Manager will arrange to take the delivery of the cheque book. When received, action as in the preceding para will be taken in respect of each cheque book.

14.2.6 The cheque book will be kept under lock and key in the personal custody of the Branch Manager who, when relieved, shall take a receipt for the exact number of blank cheques made over to the relieving Manager.

14.2.7 If the cheque book or a blank cheque is lost, it shall promptly be notified to the bank branch holding Savings Fund Account No. 2 of the branch office.

How cheques are to be written up

14.2.8 Branch Managers have to issue cheques quite often every month. It will help them much to have the following rubber stamps procured locally under the powers delegated to them.

S.No.	Description	Suggested size
1	Employees' State Insurance Savings Fund Account No. 2, _____ Branch Office	4 cm x 1cm
2	Current for three months from the date of issue.	3cm x 0.5 cm.
3	Manager, Branch Office, ESI Corporation, _____	5 cm x 1 cm
4	<u>Account payee only</u>	3 cm x 0.5 cm
5	Under Rs.....	3cm x 0.4 cm

14.2.9 All cheques will have the stamps at S. No. 1 to 3 affixed on them at the appropriate places. As for the stamp at S. No. 4, since it is incumbent for the Branch Office to make every cash benefit payment exceeding Rs. 3,000/- (exceeding Rs. 500/- in M.P. region), by 'Account Payee' cheques, this stamp will be affixed on each benefit payment exceeding the limit aforesaid in each case. There will be one line above and another line below the legend 'Account Payee only' and it shall be affixed crosswise in the top left corner or in the middle of space available on the left side of Branch Manager's signature on the cheque. Also, all cheques shall have written across them in red ink at right angles to the printed type, a sum in whole rupees just above that for which the cheque has been prepared, e.g., "Under Rupees Two thousand five hundred thirty two" will be written if the cheque is for Rs.2531/- or more but less than Rs. 2532/-. The Branch Manager will sign over the rubber stamp at S.No.3 above affixed as usual in bottom right hand corner of each cheque.

14.2.10 A cheque drawn in favour of an officer of the Corporation will be made payable to 'order' after the name of the payee.

14.2.11 A cheque drawn in favour of an insured person or a dependant and a cheque drawn in favour of a third party or a statutory authority shall be crossed with a rubber stamp "Account Payee only".

14.2.12 As a rule, no cheque should be drawn unless it is to be paid away and it shall not be drawn in favour of any person other than the payee. All corrections and alterations in a cheque shall be neatly and legibly written and attested by the Branch Manager over his full signatures. A cheque when issued shall be accounted for in the Account No.2 cash book and other records on the same date on which it is issued. Amount of the cheque drawn as well as name of the person to whom it has been issued should be indicated clearly in the counterfoil of the cheque book alongwith cheque No. and date. This entry should also be attested with dated initials of the Branch Manager.

Revalidation of Cheque

14.2.13 A cheque issued by the Branch Office may not be presented for payment within its currency period. In that case, the Branch Manager, when approached, should re-date the cheque over his full signatures and return it to the payee. A note of the fact of re-dating should be kept against the original entries in the cash book and also on the counterfoil. No fresh cheque need be issued.

Cheque Remaining Unpaid for Six Months

14.2.14 Cheques remaining unpaid for 6 months shall be cancelled and written back. The cancellation must be recorded in red ink over the signature of the Branch Manager cancelling the cheque upon the counterfoil, and on the cheque if in his possession and across the pay order on the bill or voucher. The cheque shall then be attached to the counterfoil till the accounts are audited. If the cheque is not in the Branch Manager's possession, he must promptly address the branch bank on which it is drawn to stop payment of the cheque and, on receipt of confirmation that the payment has been stopped, shall make the necessary entry in his accounts. Necessary entries will also be made in the ledger or register of PDB/DB at the appropriate place and the benefit payment docket. The cancellation of the cheque will also be reflected as a minus payment against the relevant cash benefit in the Daily Cash Return in Form A-19 as well as in the schedule sheet for the day.

Lost/Destroyed Cheque

14.2.15 If the Branch Manager is informed that a cheque drawn by him has been lost or destroyed, he shall obtain a certificate in the following form from the drawee branch bank so that the lost cheque may not be encashed:-

"Certified that cheque No. _____ dated _____ for Rs. _____ reported by Manager, Branch Office _____ to have been drawn by him on this branch in favour of _____ has not been paid, and will not be paid if presented hereafter. The bank, however, does not take any responsibility if the cheque is paid through inadvertence".

The Branch Manager, on receipt of the certificate duly signed by the drawee bank and an undertaking from the payee that no payment will be drawn by him in case lost cheque is found later, shall enter in his account the original cheque as cancelled and may issue a fresh cheque in lieu of the lost/destroyed cheque. The loss/destruction of cheque will also be noted on its counterfoil in the cheque book. The fresh cheque issued should be entered on the date of issue in red ink in the cash book but not in the column for payment.

Cancelled Cheque

14.2.16(a) When a cheque is cancelled before the cash book has been closed for the day on which the cheque is issued, the entry in the cash book, if already made, shall be struck off in red ink over the initials of the Branch Manager and the fact of cancellation of cheque shall be recorded on the counterfoil and the voucher (or ledger page and docket). However, when the cheque is cancelled after the cash book has been closed, a fresh entry in red ink "Cancelled cheque" shall also be additionally made exhibiting the amount of the cheque as a minus figure in the bank column on the payment side of the cash book. The cancelled cheque shall be pinned to its counterfoil in the cheque book. No further action is necessary if a fresh cheque in lieu is not issued. However, if a fresh cheque is issued in lieu of the cancelled cheque, the following note shall be made on the counterfoil of the new cheque:- "Issued in lieu of Cheque No. _____ dated _____ cancelled". The issue of a new cheque should be entered on the date of issue in red ink in the cash book but not in the column for payment.

(b) If the cheque is not in the drawer's possession, he must promptly address the drawee bank branch to stop payment of the cheque and, on following the procedure given in the preceding para, make necessary entry in his cash book.

Recording Benefit Payments in Cash Book

14.2.17 Detailed procedure for daily recording of benefit payments in a 'Schedule of Benefits Paid' and posting of totals of each cash benefit so recorded in the Branch Office cash book Account No. 2 has been given in paras P.3.55 to P.3.66 of Chapter III (Procedure) of this Manual. The Branch Manager shall submit daily and monthly summaries of receipts and payments in Account No. 2 in form A-19 to the Dy. Director (Finance) at Regional Office. Daily summary should be sent on the same day or, if that is not possible, on the following working day. However, monthly summary must be submitted just at the close of every month. It will be the primary duty and responsibility of the Branch Manager to adhere to these time limits.

Excess/Deficit in Cash Balance

14.2.18 Please refer to Para P.3.75 of Chapter III (Procedure).

Safety of Corpn. Funds & Important Documents

14.2.19 All articles or documents of value from a financial point of view should be kept in the safe when not in actual use, e.g. (i) cash, (ii) cash books and current vouchers (iii) receipt books (iv) stock register of receipt books, (v) cheque books and stock register of cheque books.

Branch Office Safe & Cash Box

14.2.20 The Branch Office safe should be securely fastened to the floor or the wall and the cash box to the table. The room containing the safe/cash box should not be left unoccupied during office hours when these contain cash.

14.2.21 The procedure for ensuring the safety of cash and for the use of safes and cash boxes will be as follows:-

- (i) One key each of the original set of the keys of the safe and cash box will be held by the Branch Manager and one key each by the Cashier. The original keys of the safe and the cash box with the Branch Manager and the Cashier should always be carried by each on his person.
- (ii) The set of duplicate keys of the safe and cash box should be deposited in the State Bank of India or any other authorised bank with which such arrangement exists. The duplicate keys will be placed in a stout envelope (preferably cloth-lined) or card box by the Cashier in the presence of the Branch Manager, wrapped in cloth and securely sealed with the Corporation's seal. The name

of the Branch Office to which the keys belong should be written on the packet. The sealed packet should be lodged with the bank invariably on the same day. If, due to some unforeseen circumstances or unavoidable reasons, the sealed packet cannot be deposited in the bank on the same day, it should be kept by the Manager in the cupboard which is under the personal charge of the Manager who should also hold all the keys of this cupboard. The packet should be removed from the cupboard on the next working day without fail, lodged with the bank and its receipt obtained which will be retained by the Manager in his safe custody.

- (iii) A register of duplicate keys shall be maintained in form A-7 appended below, wherein reasons for any instances of delay in deposit of the duplicate keys shall also be recorded:

Form A-7

Register of Duplicate Keys

Particulars of the chest	No. of keys	Officer with whom original keys kept	Acknowledgement	Name of bank branch	Date of deposit	No. and date of acknowledgement received from bank	Date of withdrawal	Initials of Branch Manager	Remarks
1	2	3	4	5	6	7	8	9	10

- (iv) Once a year, in each April, the keys must be sent for examination jointly by the Branch Manager and Cashier by opening and locking the safe to which they pertain and red posited under fresh seal with the bank, a note being made in the register, in the 'remarks' column that these have been checked and found correct. In case the keys are withdrawn from the bank on the change of the Branch Manager or the Cashier during the course of the year, it is not necessary to withdraw the packet from the bank in the following April for testing the keys. In offices where there are more Cashiers/Tellers than one, the duplicate keys of all the cash boxes (other than that of the Chief Cashier) sealed in separate covers/cover should be kept in the safe of Branch Office under the signatures of the Tellers, Chief Cashier (holding the key of the safe) and the Manager of the Branch Office.
- (v) Whenever there is a change in the incumbency of the Branch Manager or the Cashier, the sealed packet containing the keys should be called from the bank. The requisition calling for the sealed cover shall always be signed by both the Branch Manager and the Cashier of the office to which the keys belong and they will satisfy themselves that the seals of the packet are intact and the seals fixed are those of the Corporation.
- (vi) The keys taken out of the packet should then be tried in the presence of the person taking over. In case the person taking over be the Branch Manager, the Cashier shall always be present when the keys are tried on the safe or the cash box. Similarly, if there is a change in the Cashier, the Manager should be present. Thereafter the keys may be placed in a fresh packet and deposited in the bank as stated in sub-para (ii) above. A note of verification should be recorded in the remarks column in the register of duplicate keys.
- (vii) The handing over and taking over of the keys should always be recorded in the cash book and this entry should also be signed by the outgoing and incoming Branch Manager/Cashier.
- (viii) In case any key is lost, immediate report shall be made stating the amount of cash etc. in the safe or cash box of which the key is lost, and also the circumstances in which the key was lost. The report shall be sent to the Regional Office, which will send a preliminary report immediately to the Headquarters. It will also conduct further investigation into the causes of the loss and forward a report of its findings and the steps taken for the future to the Director General.
- (ix) The loss of the keys in all cases shall be reported to the Police authorities.

- (x) The safe in which cash is kept should always be kept locked under double lock system whereby the key of one of the two locks is held by the Manager and that of the other is held by the Cashier. The safe should not be left to be opened and locked by the Cashier alone at any time. When the safe etc., is opened, every precaution should be taken to ensure that no other person has access to its contents.
- (xi) Both Manager or Cashier, each of whom holds one of the two keys of the safe, must ensure that disbursement of cash benefits goes on smoothly in the Branch Office. However, if either Manager or Cashier is unable to come to the Branch Office on a certain day due to sudden and unavoidable circumstances, the following procedure should be followed:
 - (a) If Manager is taking leave, he should send the key held by him to next in command, e.g. Head Clerk or U.D.C other than the Cashier who will count the cash in the safe in the Cashier's presence so as to tally it with the cash as per closing balance on the previous working day, put it back in the safe from where Cashier will take out cash for disbursement. An entry will be made in the cash books. The Manager's key will be held by this seniormost official other than the Cashier for the day and handed over to the Manager on the next working day. The Manager, on resumption of duty next working day, shall similarly take back the key, count the cash in the presence of the official who held it as well as the Cashier and make entry in the cash books.
 - (b) If the Cashier is unable to attend the Branch Office on any day, he should send the keys to the Manager who will count the cash in the safe in the presence of the seniormost official in the Branch Office so as to tally it with the previous working day's closing balance and on being satisfied, make an entry in the cash books whereafter he shall follow the procedure as laid down in para 14.2.27 *infra*.
 - (c) If, on the rarest of rare occasions, both Manager and the Cashier have to be away from the Branch Office, an ESI Inspector locally posted and available may be requested to take charge. If no such official is available, payments of cash benefit and other cash transactions will have to be suspended for the day. However, other activities of the Branch Office shall continue. To avoid hardship to IPs, claims clerks should obtain request for money order by every IP at his latest but definite address where IP would be available, e.g., address of his factory, etc. and record it in the claim forms. All these claims shall be made ready for pay order by the Manager on the next day.
- (xii) All locks to the safe and cash boxes should be utilised.

Safety of Cash in Transit

14.2.22 The Hqrs. of the Corporation has taken a collective insurance policy against loss of its cash in transit, occasioned by robbery, theft or any other cause whatsoever excluding the acts of God (e.g., floods, earthquake, lightning), war or war-like perils, riots, civil commotion. This policy is renewed every year. Loss of office cash in transit should be reported immediately to the Regional Office and to the Police authorities.

Personal Safety of Cashier and Escort

14.2.23 The Corporation has similarly taken an insurance policy against personal injury to the Cashier of every office of the Corporation, while at work as well as an insurance policy against personal injury to Corporation employee while he is acting as escort to the Cashier for bringing cash from the bank. This policy is also renewed by Hqrs. every year.

Fidelity Guarantee of the Cashier

14.2.24 Every Regional Office takes a collective fidelity guarantee policy every year in respect of all the Cashiers working in the region. This policy is not in the personal name of a Cashier in position but only by designation whoever may be actually manning the job. The risk covered is limited to the daily drawal limit of each Branch Office. The premium for the collective policy is paid by the Regional Office. In addition to this policy, every person, on his appointment as Cashier, has to submit to his Branch Manager, a personal fidelity bond, in the form at Annexure-A, duly signed by him and witnessed by two persons. This bond also likewise limits the Cashier's liability in the daily drawal limit of the Branch Office in which he is employed.

When Cash Exceeds Daily Drawal Limit

14.2.25 As far as possible, total cash in the Branch Office should not exceed its daily drawal limit. However, on occasions, total cash in hand may exceed this limit. In such an event, the following precautions should be taken by the Manager:

- (i) Whenever total cash in the chest (including cash for benefit payments, imprest cash, undisbursed pay and allowances etc.) exceeds the daily drawal limit, the excess cash must be kept in the inner chest which should be duly locked by the Cashier in the presence of the Manager and its key handed over to the Branch Manager, who should keep it in his safe custody until the total cash held comes down to within the daily drawal limit. A note to this effect should be kept in the cash book Account No.2.
- (ii) On some occasions, the total cash to be drawn from the bank may exceed the daily drawal limit, e.g., on pay day etc. and it will be appropriate for the Manager to accompany the Cashier to the bank and back to the Branch Office. The cash so brought should then be disbursed as early as possible to the rightful claimants and the rest kept safely in the chest.

Cash Advanced for Spot Payment of Benefits

14.2.26 Money is occasionally advanced to a subordinate by the Branch Manager for disbursement as conveyance charges/loss of wages to IPs appearing before the Medical Board as also to the Cashier for disbursement of cash benefits to IPs of a Pay Office. The following procedure will be followed in this regard:

- (i) The subordinate/Cashier should furnish an unstamped receipt for the temporary advance.
- (ii) The amount advanced shall be noted in red ink in the cash book Account No. 2 as a temporary advance under the column "To whom paid and particulars". The date of payment of the advance will be entered in the date column. (The advance will not be entered as an actual payment in the money column because it is part of the cash balance held by the Branch Office).
- (iii) The subordinate/Cashier on his return will render the paid vouchers/dockets and the balance of the advance, totals of both together being equal to the temporary advance taken.
- (iv) The vouchers/dockets received from the subordinate/Cashier will become part of paid vouchers/dockets of the day and the balance of advance returned will become part of the Branch Office cash.
- (v) Simultaneously, entry will be made in red ink on 'Receipts' side of the cash book in column "From whom received and particulars" with date in the date column, showing the total amount disbursed and the undisbursed amount returned by the subordinate/Cashier

and a connecting reference to the entries for the advance originally paid quoted so as to link the payment of the advance with the adjustment.

- (vi) The acknowledgements mentioned in item (i) should be duly preserved for scrutiny by Audit when required.

Benefit Payments during Cashier's Absence

14.2.27(a) During the absence of Cashier from the branch office on outdoor duty or on leave of a short duration or for whatsoever reason, the Branch Manager has to assume full responsibility for disbursement of cash benefits as well as for the safety of cash in the Branch Office. For this, the Manager may entrust the job of disbursement to the next seniormost official etc., and make advances of up to Rs.5000/- at a time to him. He will keep an account of advances made and take the signatures of the cash-handling official in a notebook for every amount advanced. At the close of payments, the full account of cash disbursed, supported by the schedule of benefits paid (after being checked,) alongwith the balance left will be handed over by the stop-gap Cashier to the Manager who will make a note of it in the note book which should have the following columns:-

Date	Time	Name of official handling cash	Amount advanced (Rs.)	Signatures of official	Amount spent (Rs.)	Balance returned (Rs.)	Initials of official	Initials of Manager
1.	2.	3.	4.	5.	6.	7.	8.	9.

(b) Manager should also ensure that sufficient cash is available in the Branch Office for disbursement of cash benefits during the Cashier's absence. However, if need arises for cash during his absence, he should himself bring cash from the bank. He may take a group D employee with him as an escort and also take necessary precautions (e.g., change his return route, etc.) for safely bringing cash to the Branch Office. Alternatively, he may issue a cheque for an amount not exceeding Rs.5000/- and obtain cash through a trustworthy employee of the Branch Office. On its exhaustion, he may get more cash if found necessary by issue of a fresh cheque for similar amount. He may also issue 'account payee' cheques to those who, under instructions, can be paid in cash at the Branch Office. He may also obtain requests from IPs and other beneficiaries for payment by money order.

Classification of Expenditure on Benefits, etc.

14.2.28 Apart from the usual cash benefits appearing under the major head B-Cash Benefits in the publication *List Of Major And Minor Heads of Receipts and Disbursements* of the Corporation, and paid at every Branch Office, certain other benefits are also paid occasionally for which a specific mention has to be made in the relevant column of the schedule of benefits paid as well as in the daily/monthly cash returns (Form A-19). An illustrative list of such payments is given below:-

- A. Medical Benefit** - Medical treatment and care and maternity facilities incurred direct by the Corpn.
- Confinement Expenses.

This is paid to an insured woman as well as to an IP for his wife's childbirth at a place where medical facilities under the ESI Scheme are not available.

- B. Cash Benefits - Sickness Benefits** -
Enhanced sickness benefit

- C. Other Benefits** -
Expenditure on rehabilitation of insured persons* -
Payment of rehabilitation allowance -
(i) to an IP referred to Artificial Limb Centre

- (ii) to a disabled IP who underwent vocational training at a vocational training centre.

* For details, please refer to Chapter XII.

PART III - Transactions in Imprest Account

A. Imprest Cash Book

Transactions Recorded in Imprest Cash Book

14.3.1 Every branch office needs ready cash to meet the day-to-day expenses for its upkeep and maintenance, purchase of postage and stationery and other sundry items. Under the Schedule of Administrative & Financial Powers (copy at Annexure B), Managers of grade-I and grade-II Branch Offices have been delegated powers by the Director General to incur expenditure on various items included therein. For this purpose, a permanent imprest, literally meaning a permanent cash advance, has been provided to every Branch Office. The expenditure thus incurred from the permanent imprest is recouped through the submission of bills called "Fully vouched contingent bills" to the Finance and Accounts Branch of Regional Office for audit and recoupment of the amount so spent.

14.3.2 For recording transactions of the nature described above, an imprest cash book in form No. A-20 is maintained by the Branch Office. This cash book, being a permanent record, should be securely bound and its pages machine-numbered. On the 'Receipts' side, amounts received as described below are entered:-

- (i) Permanent imprest held.
- (ii) Amount received for disbursement of pay and allowances of officers and staff at the Branch Office. (Applicable to Branch Offices at places having no ECS facility).
- (iii) Amount received in recoupment of permanent imprest.
- (iv) Advances obtained for any non-recurring contingent expenditure which it is not possible to meet out of permanent imprest.

14.3.3 From the above description, it will be clear that at places where ECS facility is not available, apart from the transactions in imprest account, the pay and allowances when received, of the officers and staff posted at the Branch Office, are also entered on the 'Receipts' side of this cash book.

14.3.4 The imprest cash book has columns corresponding to each other on the 'Receipts' and 'Payments' side. Items of receipts entered in a column in the 'Receipts' side will have entries made in corresponding column on the 'Payments' side when payments are made out of these receipts. The procedure for making entries in the columns provided on the 'Receipts' side is as under :-

- (i) When cash is received for making payments other than benefit payments, it should be noted on the 'Receipts' side giving its particulars under the head 'Particulars'.
- (ii) The amount of pay and fixed allowances (e.g., HRA, DA, CCA, CA etc.) should be entered in column 'Pay' and of TA under the column "Allowances".
- (iii) Entry of permanent imprest on initial drawal as well as when recouped should be entered under "Contingencies in recoupment of permanent advance."
- (iv) Advances obtained for meeting non-recurring expenses may be entered under sub-column 'Contingencies-Advance Payment'.
- (v) The column 'Miscellaneous' will be used for receipts, if any, other than those mentioned above, e.g., amount of GPF advance, etc.

Operations in Imprest Account

14.3.5 The procedure for operation of imprest account of the Branch Office is explained below:

- (i) *Vide* Schedule of Powers to Branch Managers(copy at Annexure- B) every Branch Manager has been empowered to act as drawing and disbursing officer (DDO) for self, staff of Branch Office, and even for the Inspector(s) and the Medical Referee posted at his centre.
- (ii) Bills for monthly pay and fixed allowances will be prepared at the Branch Office in duplicate in the establishment pay bill forms (form A-27) separately for each group, i.e., 'A', 'B', 'C' and 'D' and one copy, duly signed by the Branch Manager as DDO will be sent so as to reach the Finance & Accounts Branch at Regional Office at least 7 days before the last working day of every month for audit purposes, the other copy being only initialled as office copy and retained in the Branch Office.

"Working day" here means the day the ESI Branch Office and the Bank Branch are both open for transacting their ordinary business.

- (iii) Contingent bills for telephones and electricity charges, etc., and rent of the Branch Office building where applicable, payable by a due date, shall also be similarly drawn and submitted so as to reach Finance & Accounts Branch at R.O. at least 7 working days before the last date of payment. **Power have been delegated to Branch Managers (Gr.I & II) vide HQ. letter No. A-38/24/99-MSU dated 08.09.03.** Now Branch Manager Gr. I and II are empowered to sanction the above said contingent bills.
- (iv) Each Branch Office will also maintain a bill register in Form A-35, for pay and allowances and a register of contingent charges in Form A-36. These registers will be reviewed monthly by the Branch Manager and the result of the review recorded therein.
- (v) The Dy. Director (Finance) at R.O. will pass the pay bills and other bills by then received from the Branch Office and, in respect of the amounts admitted in audit, he will send, alongwith a disallowance memo, if any, a payment slip (in duplicate) authorising the Branch Manager to draw a cheque for the requisite amount on the ESI Savings Fund Account No. 2 of his Branch Office.
- (vi) On receipt of the payment slip, Branch Manager will enter particulars thereof in the bill register and the contingent register against the concerned bills and draw the amount thereof from ESI Savings Fund Account No. 2 of the Branch Office at the local bank branch and indicate on that slip the cheque no. with date of drawal. A copy of the payment slip meant for the bank will be presented at the bank counter alongwith the cheque to be encashed. As indicated in the payment slip itself, the amount to be drawn on the basis of the said slip will not form part of the daily/monthly limit of drawal of funds by the Branch Office.
- (vii) The cheque drawn as above will be entered in cash book, Account No.2 of the Branch Office and in the daily cash return (Form A-19) on the payment side under the 'Bank' column only. The amount will then be entered in the imprest cash book as a receipt on the 'Receipts' side and payments will be made to individual employees out of this cash, on obtaining stamped acquittance in the office copies of the relevant pay bills. These office copies will be retained in the Branch Office. The cash thus disbursed will be recorded on the 'Payments' side of the imprest cash book which will be closed for the day.
- (viii) The payment of bills for electricity charges, telephone charges, rent of building, if any, will also be made out of cash included in the payment slip. Payment of pay and allowances of officers and staff is to be made on the last working day of each month, except the pay and allowances for the month of March which will be paid only on the first working day of April every year.

- (ix) Since the pay and allowances of the officers and staff as well as contingencies are at present paid out of Account No. 2 of every Branch Office, monthly transfers to the Account No. 2 of each Branch Office are fixed keeping in view this requirement as well as the benefit payments and other recurring expenditure.
- (x) For payment of HBA, scooter advance, GPF advance, TA/LTC advance etc. which are of an occasional nature, the Dy. Director (Finance) will send a bank draft for like amount which will be entered as a receipt in Account No. 2 of the Branch Office under the bank column. After depositing the bank draft in the ESI Savings Fund Account No. 2 of the Branch Office, the Manager will draw one or more order cheques on the bank branch in favour of the claimant(s) on the basis of amounts shown as admitted in audit in the payment slip accompanying the bank draft received from the Regional Office. It should, however, be ensured by the Branch Manager that cash benefit payments to IPs and beneficiaries are not affected by the drawal of such amounts from the bank.

Salary Payments Under ECS Facility

14.3.5A The procedure relevant to the payment of pay & allowances to officers and staff as outlined in sub-para (v) to (ix) above will apply only at places where the ECS facility is not available. At places where the ECS facility has been extended, the procedure detailed below will be followed which is applicable to monthly payment of salaries as well as other payments to staff, e.g., DA arrears, bonus, reimbursement of newspaper/magazines expenses, tuition fee, payment of T.A., L.T.C. advance/adjustment, GPF advance/ HBA, etc.:-

- (i) The Dy. Dir.(Fin.) will send to each ESI Branch Office a list showing the full particulars of officers and staff with amounts authorized to be paid to each. On receipt of this list, the Branch Manager will prepare a cheque for the total amount and send it to the Bank Branch maintaining its account number 2 alongwith a statement of amounts payable to each employee named therein and the names of the Bank Branches together with the account number of each employee, with a request to credit these accounts to each Bank account through ECS, with a corresponding debit of the total amounts to account number 2 of the ESI Branch Office. A form to be used for this purpose is suggested below:-

_____ BRANCH OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION

No. _____ Dated : _____
To, _____
The Manager,
_____ Bank _____

Dear Sir,

I enclose an 'account payee' cheque No. _____ dated _____, for Rs. _____ (Rupees _____ only) drawn on the savings fund account number 2 of this office with the request that this amount may be debited to the said account with corresponding credit of the amounts shown below to officers and members of the staff of this office, by the ECS facility :-

Sl.No.	Name of the payee	Bank branch in which account maintained	Account number	Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
			Total :	

(Rupees _____).

yours faithfully,

()
Branch Manager

- (ii) As per the requirement of the bank, the ESI Branch Office Manager should send a floppy containing the above information to enable the bank to credit each individual account in the State Bank of India.
- (iii) In every case where a claim is disallowed or reduced in audit, Dy. Director(Fin.) will send a disallowance memo in respect of any amount(s) not admitted in audit

B. Matters Connected with Personal Claims

Office Orders re: Appointments/Transfers

14.3.6 An office order showing (i) the post to which appointed (ii) the date and hour (forenoon or afternoon) from which the appointment takes effect and (iii) the scale of pay applicable to the post will be issued by the Director General or any other officer duly authorized by him in his behalf. Where the office order is signed by an officer other than the Director General, the fact that the appointment has been made by the competent authority shall invariably be stated therein. A copy each of such office order shall be endorsed to (i) Regional Director, in case of Manager/Inspector, (ii) Finance & Accounts Branch at Regional Office and (iii) Manager/Inspector concerned. Similar office orders will be issued for lower staff whose appointing authority is the Regional Director.

Charge Reports

14.3.7 In the case of Manager/Inspector etc., a charge report showing the date and hour (forenoon or afternoon) on which the charge of the post is taken over shall be signed in quadruplicate in form A-21 (see Annexure-C) and two copies thereof shall be forwarded to the Regional Office (Administration Branch) which will attest one copy and forward it to the Finance & Accounts Branch at Regional Office. In case of Branch Manager, one advance copy shall be forwarded to the Finance & Accounts Branch so as to enable them to issue bank authority in favour of the new Manager. Since the transfer of charge involves assumption of responsibility for cash, stores, etc., the following procedure should be followed:

- (i) The cash book(s) and/or imprest account should be closed on the date of transfer and a note recorded in it over the signature of both the relieved and relieving officers, showing the cash and imprest balances, the number of unused cheques, unused receipt forms and the numbers of keys of safe and cash boxes, if any, made over and received by them respectively. A record of handing over and taking over of receipt books not brought in use may be made in the stock register of receipt books (form A-5). (The above procedure will also be followed when a Cashier is relieved).
- (ii) The relieving Manager in reporting that the transfer has been completed should bring to notice anything irregular or objectionable in the conduct of business that may have come officially to his notice. He should examine the accounts, count the cash, inspect the stores, count, weigh and measure certain selected articles in order to test the accuracy of the records. He should also describe the state of account records.
- (iii) In the case of any sudden casualty occurring or any emergent necessity arising for an officer to quit his charge, the charge can be handed over to the Dy. Manager or where only the Manager is posted, the charge may be handed over to Head Clerk/Assistant/Upper Division Clerk/Cashier who is in position.

Pay Slips

14.3.8 On receipt of office order of appointment from the competent authority as well as the charge report and the last pay certificate in respect of the Branch Manager/Inspector, an authority called 'Pay Slip' showing the rates of pay and allowances admissible will be issued by the Dy. Director (Finance) in Regional Office. The pay and allowances of the Manager/Inspector will be drawn in accordance with such a pay slip only. The pay slip will also be attached with the first establishment pay bill in which the pay and allowances of the newly appointed Manager/Inspector is drawn.

First Payment of Pay & Allowances

14.3.9 When the name of Manager/Inspector/other staff is included in the first pay bill after taking over charge as Manager/Inspector or on reporting for duty as other staff, the pay bill will be duly supported by:-

- (i) The pay slip if newly appointed.
- (ii) Last pay certificate (LPC) if transferred to the same post from another region. This should be obtained by the transferred employee himself from his last audit officer/DDO, as the case may be.
- (iii) Medical Certificate of fitness for service if freshly joining service in the Corporation.
- (iv) Name of the branch of SBI in which he has his saving account alongwith his account No.

14.3.10 If the LPC is not available or, for some reasons, pay slip cannot be issued, the Dy. Director (Finance) may be requested for a provisional pay slip which will be issued initially for a period not exceeding three months so as to enable the drawal of pay and allowances for the concerned employee. Provisional pay may be drawn and, in the meantime, no effort should be spared to obtain the LPC/pay fixation memo., etc.

Payment on Quitting Service/Suspension

14.3.11 In case of an employee of the Branch Office finally quitting service of the Corporation by retirement, resignation, discharge, dismissal, death or otherwise or being placed under suspension, normally the last payment of pay and allowances to him should be made only after the Branch Manager has satisfied himself, by reference to his own records or to other appropriate authorities, where necessary, that there are

no demands outstanding against him. If such dues, if any, remain to be assessed and realised, the matter may be referred to the Regional Director to decide the amount of surety in cash or by bond or by withholding a part of gratuity payable to him and, on compliance of the instructions received from the Regional Director, the required surety should be obtained from the concerned employee to the Branch Manager's satisfaction, or part of gratuity withheld as decided by the Regional Director and the last payment of pay and allowances may be made and the last pay certificate also issued to the outgoing employee.

Payment on Death

14.3.12 Pay and allowances in respect of deceased employee may be drawn upto and including the day of his death, a day for this purpose being reckoned as beginning and ending at midnight. Pay and allowances of a deceased employee, including arrears, if any, accruing to him, should be paid in accordance with para 177 of the Manual of Audit & Accounts of the Corporation (Third Edition). Alternatively, the matter may be referred to the Regional Director for directions.

Payment to Employee on Tour

14.3.13 At places where the ECS facility is not available, pay and allowances of an employee are ordinarily to be paid at the headquarters of the employee concerned. However, if the employee is on tour and desires the payment to be made to him at his tour address, the DDO shall remit the amount to him by bank draft at par or postal money order. The charges involved in sending the bank draft by registered post or in remitting the dues by money order shall be borne by the Branch Office and charged to contingencies.

Payment on Transfer in the Middle of Month

14.3.14 In case LPC of a transferred employee reveals that he did not receive his pay and allowances for part of the month in his old post, the same may be drawn after he joins duty in the new post. However, in case his pay and allowances for the period he served in his old post had already been drawn but could not be paid to him before he left his old post, the same should be remitted at par to the office to which the employee has been transferred and its Head of Office will disburse the amount to the concerned employee and send the acquittance obtained from him to his old office. However, if the transferred employee is willing, based on a letter received from him, the amount may be credited to his account through the Electronic Credit System (ECS) by the Manager of the old Branch Office under intimation to the employee.

Deductions from Bills

14.3.15 Generally, deductions of the following types are made from the pay bills of officers and staff of the Branch Office: -

- (i) Provident fund
- (ii) Postal Life Insurance
- (iii) License fee & water charges
- (iv) Income tax
- (v) Sums disallowed in one pay bill against which full payment was made, to be made from the next bill on receipt of disallowance memo from Dy. Director (Finance) of Regional Office.
- (vi) Part of TA advance found recoverable on admitting a TA bill for a lesser amount submitted on completion of journey.
- (vii) Part of pay of an employee as attached by a court order, subject to rules.
- (viii) Dues of a co-operative society.
- (ix) Profession tax levied by Government of the State in which the Branch Office is located and functions.
- (x) Contribution to group insurance scheme
- (xi) Contribution to CGHS, if applicable.

14.3.16 The procedure for deductions has been provided in paras 163 to 172 of the Manual of Audit & Accounts (3rd Edition) and may be consulted and, in case of any doubt, directions may be sought from the Regional Office.

Payment through Agent

14.3.17 Subject to the exception made in the succeeding para, where an employee, being on leave or on tour, is unable to present himself in person to receive his leave salary or pay and allowances, he may be allowed to receive it through a messenger. For this, he must furnish through the messenger a legal acquittance for the money payable, signed by himself alongwith a letter of authority in the following form:-

"I hereby authorise Shri _____ s/o _____ resident of _____ whose signatures are attested below, to receive the leave salary/pay and allowances due to me for the period from _____ to _____.

Signature of messenger

Signature of employee

Attested

Signature of employee

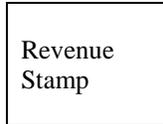
* * * * *

Received Rs. _____ (Rupees _____) from the Manager, Branch Office, ESI Corporation _____, being my leave salary/pay and allowances for the period from _____ to _____

Place:

Date:

Signature



The authority letter alongwith the stamped receipt will be surrendered with the Manager. The messenger will also acknowledge the amount through an unstamped receipt for the money received. This will be pasted with the office copy of the pay bill of the concerned employee.

14.3.18 The procedure for payment of salary through agent described in the forgoing para will not apply at places where ECS is in force. In such a place, the salary of the employee who is on leave or on tour shall be credited direct to his account under ECS in the scheduled bank as per instructions.

Pay & Allces. of Manager/Inspector etc. at Centre

14.3.19 The rate of pay, leave salary and fixed allowances of Manager/Inspector and other officers (e.g., Medical Referee) at the centre shall continue to be drawn unless increased or changed by the orders of the competent authority, followed by a revised pay slip issued by the Dy. Director (Finance). Similarly, no reward or honorarium will be drawn in favour of the said Manager/Inspector or other officers unless sanctioned by the competent authority.

14.3.20 No bills shall be drawn in favour of any Manager/Inspector or other officer at the centre who has relinquished charge of his post on his proceeding on leave, promotion, reversion or transfer, beyond the date of making over charge without a fresh authority from the Dy. Director (Finance).

14.3.21 If the Manager/Inspector or other officer at the centre returns/is appointed to the same post from which he proceeded on leave, the pay slip issued for duty pay (before proceeding on leave) will be treated as valid for duty after leave unless superceeded for payment duly supported with charge report on resumption of duty.

Absentee Statement

14.3.22 As stated in para 14.3.5(ii) above, separate monthly pay bills will be got prepared by the Branch Manager for Group- C and D employees of the Branch Office in form A-27 and signed and presented by him to the Dy. Director (Fin.) by the time limits laid down in the said para. Each bill shall be supported by an absentee statement in form A-28 (see Annexure-D) which should cover the period of one month from the 11th of previous month 10th of the current month. This absentee statement will be necessary only if any person was absent during the period either on special duty or on suspension or with or without leave other than casual leave or when a post is left vacant substantively, whether officiating arrangements have or have not been made against it. If every member of the staff was present or some one was only on casual leave, or was on tour duty during the period, a 'NIL' statement may be enclosed.

Increment Certificate

14.3.23 Branch Managers have been delegated full powers to grant increments to the staff working under them. Periodical increment certificate should be filled in form A-29 at the time when an increment becomes due according to the stage in the scale of pay of the post, signed by the Branch Manager and attached with the paybill in which the pay increased by the increment is drawn for the first time. If grant of increment is delayed for some reason and arrears of increment have become payable, the arrears should be drawn in a separate bill.

Overtime Allowance

14.3.24 Under the Schedule of Powers *ibid*, Branch Managers have been empowered to sanction overtime allowance to the staff as under:-

- (i) Branch Manager Gr.I - up to Rs.150/- p.m.
- (ii) Branch Manager Gr.II - up to Rs. 75/- p.m.

Grant of OTA is subject to any orders issued by the Corporation in this behalf. Every bill in which OTA is claimed shall contain a certificate from the Branch Manager as follows:-

" Certified that ---

- (a) the persons for whom overtime allowance is claimed in this bill have actually earned it by working overtime;
- (b) the periods for which overtime allowance is claimed in this bill have been checked with the initial records and found correct;
- (c) the overtime allowance is claimed at rates sanctioned by the competent authority; and
- (d) the overtime allowances have been taken into account in calculating the income tax due from the employees noted in this bill."

Service Books & Leave Accounts

14.3.25 Service book and Leave account will be maintained as per Govt. of India rules in this respect.. The leave account of every employee of the Branch Office will be maintained in the Branch Office in form-A-31. Blank forms may be obtained from Regional Office and kept in stock for use when needed.

Under the Schedule of Powers *ibid*, the Branch Manager can grant earned leave, half-average pay leave and commuted leave under the rules to his employees as follows:-

Branch Manager Gr.I - Up to 30 days
Branch Manager Gr.II - Up to 15 days

It is to be noted that in case of commuted leave, limit of 15 days means 15 days of uncommuted leave and not 30 days of it commuted to 15 days of full pay leave. In other words, a Branch Manager Gr.II can practically sanction half pay leave commuted to full pay leave up to 7 days only.

14.3.26 Whenever an application for leave of any kind described above is received, the Branch Manager before sanctioning leave, should satisfy himself that the period and the nature of leave applied for is admissible and within his powers; if not, he should refer the matter to Regional Office alongwith his recommendations about the grant of leave and, if he considers so, for posting of a substitute or for officiating arrangements, if admissible.

14.3.27 Whenever Audit Party visits the Branch Office, the service books and leave accounts of the staff should be handed over to them for checking and audit whereafter the incharge of the Audit Party will record a certificate as follows and initial it with date:

"Checked for the period ----- (subject to remarks in the test audit note)"

Arrear Bills

14.3.28 Arrears of pay, fixed allowances or leave salary shall be drawn in a separate bill, the amount claimed for each month being entered separately with quotation of the bill from which the charge was omitted or withheld, or on which it was refunded by deduction or of any special order of competent authority granting a new allowance or an increase in pay. A note of the arrears bill shall invariably be made in the office copies of the bills for the period to which the claim pertains over the dated initials of the drawer of the arrear bill, in order to avoid the risk of the arrears being claimed over again. The Branch Manager shall also record the following certificates on the arrears bill over his dated signatures:-

' Certified that -

- (i) No part of the amount has been drawn previously, and
- (ii) A note of the arrears claimed has been made in the office copy of each of the bills for the period to which the claim pertains. '

It is to be noted in this connection that claims of pay, fixed allowances or leave salary etc., which have become time-barred, should be preferred only after the reasons for delay are investigated and sanction of competent authority has been obtained.

Travelling Allowance Bills

14.3.29 A traveling allowance bill must be submitted within one year of the date on which claim for traveling allowance becomes due. A TA claim becomes due on the date following the date on which, generally speaking, the journey is completed. In case of transfer of a Corporation employee, the due date in respect of self, his family, personal effects, will be reckoned as the date following the date on which journey is completed by the Corporation employee, by the family members and the transportation of personal effects is completed. The following instructions are laid down:-

- (1) Bills for travelling allowance other than fixed allowances, shall be submitted in the following forms:-

Manager / Inspector and other officers - Form A-26
Other establishment - Form A-32

- (2) Instructions printed on the relevant forms of the bill will be strictly observed while preparing and submitting the TA bills.
- (3) When a circuitous route is taken, the reasons for doing so should be invariably stated.
- (4) When actual expenses are drawn for conveyance hire, full details thereof should be furnished in the TA bill, e.g., auto rickshaw or taxi no. etc.
- (5) When claiming TA for family members, the number and relationship of each family member should be furnished.
- (6) The TA bills of establishment which will be signed by the Branch Manager as well as those of the self-drawing officers at Branch Office should be submitted to the Controlling officer for countersignature and onward transmission to the Dy. Director (Finance) for pre-audit and payment.

Reimbursement of Medical Expenses

14.3.30 The expenditure incurred by, and to be reimbursed to the employee on account of medical attendance and treatment, may be drawn in establishment pay bills. Every bill so drawn must be supported by proper certificates from the medical attendant, receipts and vouchers and must be submitted within three months of its becoming due for payment. A claim for medical reimbursement, generally speaking, becomes due for payment on the last date of treatment or, in the case of prolonged illness, last date of the period in respect of which a claim is preferred.

Disbursement of Pay and Allowances

14.3.31 In places where the ECS facility is not available, the following procedure will be followed in respect of disbursement of pay & allowances :

- (a) The Branch Manager as Head of Office is personally responsible for the amount drawn on a bill signed by him or on his behalf until he has paid it to the persons entitled to receive it and obtained a legally valid acquittance on the office copy of the bill with simultaneous entries in the cash book.
- (b) If any amounts remain undisbursed and are paid subsequently, the item in the acquittance roll/office copy of the pay bill should be stamped 'PAID' individually and attested by the Branch Manager when signing the cash book.
- (c) An account of undisbursed pay and allowances be kept in a register in form A-34 (see Annexure E). Entries of the total and particular amounts of undisbursed pay and allowances may be made against each bill serially, and subsequent payments thereof entered in the appropriate columns of the register and the cash book, each such entry being attested by the Branch Manager.
- (d) Amounts of pay and allowances remaining undisbursed within the course of the month should be refunded either in cash or by short drawal in the next bill. However, when Branch Manager is of the opinion that such a step is likely to operate inconveniently, the amount of undisbursed pay and allowances; at his option, be retained for any period not exceeding three months; meanwhile Branch Manager should ensure for the safe custody of the sums retained.

Preservation of Pay Bills

14.3.32 Office copies of bills, being important records, should be stamped 'PAID' and preserved carefully for a period of 35 years. They should be bound yearly or half-yearly if the lot becomes bulky. The binding should be of sufficiently durable material. They may be preserved in guard files if that is considered more strong and durable. A certificate regarding preservation of pay bills and acquittance rolls should be forwarded by the Branch Manager every year by 30th June to the Dy. Director (Finance).

Bill Register

14.3.33 As stated in para 14.3.5(iv), a bill register in form A-35 (see Annexure-F) should be maintained by the Branch Manager and details of all bills (other than contingent bills) submitted by him should be noted in it. This register should be reviewed monthly by the Branch Manager and the result of review recorded therein.

C. Contingent and Miscellaneous Expenditure

Imprest for meeting day- to-day expenditure

14.3.34 As stated in para 14.3.1, Manager of every Branch Office is provided with permanent advance or imprest to enable him to meet his day-to-day expenditure incidental to the upkeep and management of the Branch Office under his charge, and that the money spent out of this imprest under powers delegated to him is recouped through fully vouched contingent bills (Form A-37).

14.3.35 Normally, sufficient permanent imprest is granted to every Branch Office to meet its day-to-day requirements and the same should be sufficient if Branch Manager adheres to the practice of presenting recoupment bills twice, on 1st and 15th of every month. However, at times new responsibilities added to a Branch Office coupled with price-rise may make the present imprest insufficient and may threaten to block the day-to-day activities enjoined on the Branch Office. Branch Manager should envisage such trends and apply for an upward revision of his imprest. His application for revision should give full justification for the revision and should be accompanied by a statement showing month by month the amounts of contingent bills recouped with classified details of the items of expenditure.

14.3.36 The holder of the permanent advance shall be responsible for the safe custody of money placed in his hands and he must at all times be ready to account for the total amount of the money.

14.3.37 In the event of transfer of Branch Manager, on the date of transfer of charge and yearly by the 15th April every year, each Branch Manager should send to the Dy. Director (Finance) of his region, an acknowledgement as on the date of transfer of charge or as on 31st March preceding, as the case may be, the total amount of imprest sanctioned to the Branch Office, consisting of (i) cash in hand, (ii) amount of unrecovered vouchers and (iii) the amount of recoupment bill sent to the Dy. Director (Finance), recoupment in respect of which is awaited.

Unusual Expenditure

14.3.38 As per Schedule of Powers *ibid*, Branch Managers Grade I/II can incur expenditure of a miscellaneous and contingent character upto Rs. 500/- / Rs. 200/- at a time (without annual financial limit). It may sometimes happen that a Branch Manager has to incur unprecedented expenditure which is beyond the schedule of powers delegated to him. In such an event, he should refer his proposal to the R.D. giving full justification. On receipt of sanction, he should get the work done and while submitting the bills for payment invariably quote the number and date of the communication whereunder the sanction for the expenditure was communicated. However, at times, the payment may have to be made by a due date to avoid punitive surcharge, etc., so that Branch Manager cannot await the receipt of sanction from Regional Director and/or the amount from the Finance Branch of the Regional Office. In such an event, the Branch Manager may either –

- (i) submit an abstract contingent bill in form A-38 (Annexure-G) for drawal of advance with his letter justifying his proposal and requesting for sanction in which case it will be necessary for the Regional Director to record his sanction for the expenditure on the letter itself whereafter it will be passed on to Finance & Accounts Branch for paying the advance to the Branch Manager concerned,

OR

- (ii) make payment from his imprest if funds available therein are sufficient to meet the payment and immediately thereafter present the recoupment bill to the Deputy Director (Finance) at Regional Office. Such a course can be adopted only if the sanction to the expenditure has already been received. Alternatively, Regional Director may sanction the expenditure on the bill itself and on its receipt in Finance Branch, the amount will be remitted to the Branch Manager forthwith.

If any amount was drawn as an advance on submission of abstract contingent bill, this will have to be followed by submission of a detailed contingent bill (Form A-39), superscribed "NOT PAYABLE" alongwith sub-vouchers etc. to Dy. Director (Finance) within 7 days of the last day of incurring the expenditure. The Dy. Director (Fin.) will admit the bill in audit if it is found in order and remove the entire advance from his objection book.

Instructions on Payments from Contingencies.

14.3.39 The following general instructions are laid down for guidance of Branch Managers: -

- (1) Every item of expenditure incurred by the Branch Manager must either be within his extant delegation or be supported by sanction of the competent authority.
- (2) The expenditure should be within the available appropriation.
- (3) The items of expenditure should be of obvious necessity and paid for at fair and reasonable rates.
- (4) Every voucher should be in order and the calculations therein correct and the claim paid to person entitled and his acquittance obtained.
- (5) While considering whether a claim should be paid from his permanent imprest or not, Branch Manager should keep in view the cash in hand in his imprest account and should also make a fair estimate of (i) his immediate commitment to incur any other expenditure, (ii) the recoupment expected in respect of contingent bill already submitted, etc., and decide whether to pay from the imprest available or to prefer a bill for obtaining advance before making payment to the claimant.
- (6) Those sub-vouchers which are not required to be submitted to Finance & Accounts Branch, should be duly cancelled with the rubber stamp 'PAID' or by a double line across each in red ink, duly intialled by the Branch Manager and kept with the office copy of the contingent bill. The Branch Manager will certify on the recoupment bill that sub-vouchers other than those attached to the bill have been so defaced that they cannot be used again. No sub-voucher thus retained shall be destroyed until after a period of three years.
- (7) Sub-vouchers which are required to be sent to the Finance & Accounts Branch with the recoupment bill should not be cancelled by the Branch Manager as these will be cancelled and preserved in the Finance & Accounts Branch.

Persons Employed Part-time

14.3.40 *Vide* item BO-A.4 of Schedule of Powers (see Annexure-B) delegated to Branch Managers, employment of part-time sweepers/scavengers/water carriers is within the competence of Branch Manager albeit subject to certain conditions stated therein. The contingent bill on which remuneration paid to these persons is recouped should have a certificate recorded and signed by the Branch Manager as follows:-

"Certified that the part-time sweeper/scavenger/ water carrier whose wages are drawn in this bill was actually entertained in Corporation service during the period concerned and payment has been made at the market rates".

Local Purchases

14.3.41 Whenever any local purchases are to be made, these should be made by adhering to the procedures laid down by Regional Office from time to time. Also, where laid down, quotations should be called from firms of repute and articles purchased from suppliers quoting lowest rates consistent with quality and workmanship. A certificate to this effect should be recorded and signed on the cash voucher.

14.3.42 Payment should be made only if articles have been received in good condition and according to specifications indented for. The articles should be entered in the relevant page of the appropriate stock register. The following certificate should be recorded on the contingent voucher :

"Certified that the articles paid for have been received in good condition according to the specifications indented for and their quantity/ number has been verified and entered on page ____ of the stock register of furniture/stationery/general articlesetc."

14.3.43 If sales tax/VAT has been paid on the purchases, it should be certified that goods purchased are not exempt from sales tax/VAT applicable.

Building Rent and Electricity Charges

14.3.44 Contingent bills for payment of telephone charges, electricity charges and rent of building, if the Branch Office is functioning in a rented building, will be sent to Finance & Accounts Branch in the manner stated in para 14.3.5(iii). The following certificates will be recorded and signed by Branch Manager on the contingent bill:

"Certified that –

- (a) the amounts drawn on account of rent, rates and taxes, etc. in the previous contingent bill No. _____ dated _____ have actually been paid to the parties concerned; and
- (b) the amounts drawn in this bill will be paid to the parties on realisation.
- (c) no portion of the building was utilised for residential or other purposes during the period."

Refreshments at Local Committee Meeting

14.3.45 A Branch Manager has often to conduct meetings of the Local Committee and to incur expenditure on tea and coffee and light refreshments including cold drinks etc. at such meetings. He has full powers to spend upto Rs. 10 per head per meeting subject to a maximum of Rs. 100/- per meeting. While submitting the recoupment bill, the Branch Manager should record the following certificate on the cash voucher:-

"Certified that the expenditure on entertainment charges included in this bill was incurred in accordance with the terms and conditions laid down by the Standing Committee of the Corporation from time to time, and that the prescribed monetary limit per head has not been exceeded."

Register of Contingent Charges

14.3.46 As stated in para 14.3.5(iv), a register of contingent charges in form A-36 shall be kept in every Branch Office and every payment, as soon as it is made under each detailed head under the major head 'Contingencies', shall be recorded in this register and duly authenticated by the Branch Manager with his initials on the same day. This register will be reviewed monthly by the Branch Manager and the result of review recorded therein.

14.3.47 Generally, in a Branch Office, contingent expenditure incurred is booked under the following detailed heads under the major head B-Field Work - Contingencies:-

- (a) (i) Postage and telegram charges
- (a) (ii) Telephone charges
- (b) (i) Stationery
- (b) (ii) Forms
- (c) (ii) Repair, maintenance & hire charges of typewriter and computer
- (d) (i) Rent of building
- (d) (ii) Rates and taxes (e.g., electricity and water charges, house tax, ground rent and other taxes in respect of buildings owned by ESIC)
- (e) (ii) Furniture - Repair, maintenance and hire charges
- (f) (ii) Special equipment for records - repair, maintenance and hire charges
- (g) (i) General articles of office use - purchase of
- (g) (ii) General articles of office use - Repair, maintenance and hire charges
- (h) (i) Cycles - purchase of
- (h) (ii) Cycles - repair and maintenance
- (j) Books, periodicals and other publications
- (k) Hot and cold weather charges (includes payment to water sprinklers)
- (l) (ii) Miscellaneous

For details of articles/items covered under each head as given above, reference may please be made to the publication known as 'The List of Major and Minor Heads of Receipts and Disbursements of the Corporation.'

14.3.48 Out of the list given above, which has been drawn up keeping in view the expenditure generally incurred at a Branch Office, the Branch Manager may enter only those items on which expenditure is generally incurred in his office and leave out others. If any expenditure is incurred under a detailed head not included in the register, the same may be opened if space is available or it may be entered under the column 'Unusual Charges'. **The Dy. Director (Finance) will provide to each Branch Office the budget appropriation made at the beginning of each financial year under the head 'Contingencies'.** This, when received, may be entered in the appropriate column. The progressive expenditure under 'Contingencies' should, as far as possible, be kept within the budget appropriation. However, in case the expenditure is likely to exceed the appropriation, its upward revision should be sought, giving full justification.

14.3.49 While submitting every recoupment bill, a red line should be drawn across the page of the register of contingencies, expenditure booked under each detailed head totalled up and posted in the fully vouched contingent bill (Form A-37) under each detailed head and submitted to Dy. Director (Finance) for recoupment. This detailed bill will be fully supported by sub-vouchers. Before submitting the recoupment bill, a copy of it should be retained by the Branch Office as office copy.

PART IV-General

(Applicable to All Financial Transactions of a Branch Office)

Accounts : Manager's Personal Responsibility

14.4.1 Every Branch Manager is personally responsible for the completeness and strict accuracy of the accounts rendered and for their despatch within the specified dates.

Look before You Sign a Ptd. Certificate

14.4.2 A Branch Manager who signs or countersigns a certificate is personally responsible for the facts certified to, so far as it is his duty to know or to the extent to which he may reasonably be expected to be aware of them. So, before signing a printed certificate, he should make sure that it represents the facts and if it does not, he should modify the certificate.

Maintenance of Cash Books

14.4.3(a) All cash books shall be maintained in bilingual form (English & Hindi) and shall be strongly bound and machine page-numbered before being brought to use. All money transactions shall be neatly entered in them. Any corrections, if found unavoidable, shall be neatly made in red ink (a single line being drawn through the original entry which it is desired to correct) and attested by the dated signatures of the Branch Manager. Absolutely no erasures or over-writings shall be made in registers, statements, cheques, vouchers or accounts of any description.

(b) Whenever any new cash book is received, its pages should be counted and it should also be ensured that each page is actually the same as the machine number appearing on it. If satisfied, the Branch Manager should record on the page before machine-numbered page 1 of his cash book, the following Certificate:

“Certified that I have this day counted the pages in this cash book and have found them to be _____ in number”

(c) When any new cash book is opened after exhaustion of the old one, the closing balance of old cash book which becomes the opening balance on page-1 of new cash book, should be duly certified over Branch Manager's signature as follows, respectively :-

In the old cash book:

“Closing balance of this cash book carried over to the new cash book.”

In the new cash book:

“Closing balance of old cash book brought forward as opening balance in this cash book.”

(d) New cash book A/c. No. 2 of the Branch Office will also contain the following additional entries on the page before its machine-numbered page 1:-

- (i) Daily and monthly withdrawal limits of the Branch Office, quoting Hqrs. /R.O. reference No. and date.
- (ii) The period of validity of the Cashier's fidelity guarantee policy, quoting Hqrs. Memo. No. and date.

Rounding off

14.4.4 Transactions involving paise shall be rounded off to the nearest rupee in case of pay and allowances, leave salary, pension etc. at the totals stage (50 paise and above to the next higher rupee, less being ignored.) In case of emoluments fixed by law, the amount of paise shall always be rounded to the next higher rupee. (See also para P.3.27).

Payment into Bank

14.4.5 When money is paid into the bank, the figures of amount acknowledged by the bank should be compared by the Branch Manager with the figures of the amount deposited so as to satisfy himself that the amount deposited has been actually credited by the bank.

Other Important Matters

14.4.6 Private cash should under no circumstances be mixed with Corporation's money.

14.4.7 The employment of peons to fetch or carry money should be discouraged. When it is absolutely necessary to employ a Group D employee for this purpose and when the amount to be handled is large, a man of some length of service and proved trustworthiness should be entrusted to this job and, if necessary, another employee of the Branch Office should accompany him.

14.4.8 All signatures and initials in the cash book shall be dated.

Physical Verification of Cash Balances

14.4.9 The cash balances with the Cashier in account No.2 and imprest account shall be physically verified by the Branch Manager at least twice a month and invariably on the last working day of the month. Whenever it is not possible to verify cash balance on the last working day itself, because of disbursement of pay and allowances on such day, the verification may be done on the first working day of the following month before making any transaction on that day. However, in the month of March, the physical verification of the cash balances is to be done on the last working day itself.

14.4.10 Deputy Director (Finance) and the Asstt. Director (Finance) as well as other inspecting officers of Regional Office have the power to physically check the cash balances of the Branch Office. The result of physical verification should be recorded in the cash books and discrepancies, if any, should be brought to the notice of the next superior officer.

14.4.11 A certificate in the following form shall be recorded by the Manager / visiting officer:-

Cash Book A/c No.2

I have physically verified the cash in hand in A/c No.2 of this office today afternoon/forenoon after/before closing/opening of business and found it to be Rs. _____ (Rupees _____) which agrees with the closing/opening balance of today/previous day.

Date: _____ Designation: _____ Signature: _____

Cash Book Imprest Account:

I have physically verified this office imprest cash in hand today afternoon / forenoon after / before closing / opening of business and found it to be as follows:-

Cash in hand	Rs.....	
Unrecouped vouchers (details)	Rs.....	
Total of cont. bill No. dated....., for which recoupment awaited :	Rs.....	
	Total Rs.....	(I)

Permanent imprest held by B.O.	Rs.....	
Discrepancy, if any :		
Tempy. advance	Rs.....	(ii)
Other items (details)	Rs.....	(iii)
	Rs.....	
Total (i), (ii) & (iii)	Rs.....	

Actual Cash Balance in hand Rs.(Rupees.....), which agrees with the closing / opening balance shown in imprest cash book on the previous day/ today.

Date _____ Signature: _____ Designation _____

PART V – Branch Manager’s Role As Member Of Hospital Development Committee

ESIC has set up a large number of hospitals and dispensaries in the country and a strong need has existed not only for their proper maintenance and upkeep but also for the upgradation and improvement in the delivery of health care services provided by them. For this purpose, Hospital Development Committees for all ESI Hospitals are being set up all over the country *vide* Hqrs. Letter no. U-16/18/1/07-Med.I dated July 23/24,2008, copy at Annexure H. Each such Committee will have, among others as its member, the Branch Manager to be nominated by the Regional Director of the region in which the hospital is situated.

2. The role to be played by the Branch Manager has been clearly and elaborately laid down in the Hqrs. circular at Annexure H and it needs to be gone through carefully for compliance by those Managers who are nominated on these committees. Apart from his duties as head of the Branch Office, Manager’s role and initiative will be crucial to the smooth functioning of the Hospital Development Committee.

FORM OF SECURITY BOND (FIDELITY BOND DEPOSITED AS SECURITY)

KNOW ALL MEN BY THESE PRESENTS THAT I, _____ am held and firmly bound unto the Employees' State Insurance Corporation (hereinafter referred to as "Corporation"), their successors and assigns in the sum of Rs. _____ (Rupees _____) to be paid to the Corporation for which payment, well and truly to be made, I bind myself, my heirs, executors, administrators and legal representatives by these presents.

Signed and dated this _____ day of the _____ 20

2. WHEREAS the above bounden _____ was on the _____ day of _____ 20 _____ appointed to and now holds the office of Cashier/ Teller in the _____ office of the Corporation at _____ AND WHEREAS the said _____ by virtue of holding such office is bound to collect, keep in safe custody and disburse cash and in particular to receive and disburse moneys for the payment of cash benefits to the insured persons, payment of pay and allowances, contingent bills, medical reimbursement bills, traveling allowances bills, etc., and to be entrusted with the custody and drawl and payments from the permanent advance of the _____ office, _____ and also to go to the Bank and other offices of the Corporation to receive or deposit or disburse moneys there and to keep and render true and faithful accounts of his dealings with all property and money which may come into his hands or possession or under his control, such accounts to be kept in the form and manner that may, from time to time, be prescribed by duly constituted authority and also to prepare and submit such returns, accounts and other documents as may, from time to time, be required of him.
3. AND WHEREAS the said _____ in pursuance of the instructions of the Corporation hereby authorizes the Regional Director _____ to include his name for the sum of Rs. _____ (Rupees _____) in the collective fidelity Guarantee Bond taken by the Regional Director _____ from the Insurance Company _____ of the duties of his said office and of any other office requiring security to which he may be appointed at any time and of other duties which may be required of him while holding any such office as aforesaid and for the purpose of securing and indemnifying the Corporation against all loss, injury, damage, costs, expenses which the Corporation may in any way, suffer, sustain, or pay, by reason of the misconduct, neglect, oversight or any other act or omission of the said _____ or of any person of persons acting under him or for whom he may be responsible.
4. AND WHEREAS the said _____ has entered into the above bond in the sum of Rs. _____ (Rupees _____) conditioned for the due performance by him, the said _____ of the duties of the said office and of other duties appertaining thereto or which may lawfully be required of him and to indemnify the Corporation and the Servants of the Corporation against loss from or by reason of the acts or defaults of the said _____ and of all and every other person and persons aforesaid.
5. NOW THE CONDITION OF THE ABOVE WRITTEN BOND IS such that if the said _____ has, whilst he has held the said office of Cashier/ Teller as aforesaid, always duly performed and fulfilled the duties of his said office and if he shall, whilst he shall hold the said office or any other office requiring security to which he may be appointed, or in which he may act, always duly perform and fulfill all and every duties thereof respectively and other duties which may from time to time, be required of him while holding any such office as aforesaid, and shall duly pay into the account of the Employees' State Insurance Fund, all such moneys and securities for money as are payable and deliverable to the Corporation and shall come into his possession or control by reason of the said office and shall duly account for and deliver up all moneys, papers and other property which shall come into his possession or control by reason of the said office and if the said _____ his heirs, executors, administrators or legal representatives shall pay or cause to be paid unto the Corporation or the said Employees' State Insurance Fund the amount of any loss or defalcation in the accounts of the said _____ within 24 hours after the amount of such loss and/or defalcation shall have been demanded from the said _____ by the Corporation, such demand to be in writing and left at the office of last known place of residence of the said _____ and shall also at all times indemnify and save, and keep harmless the Corporation from all and every loss, injury, damage, actions, suits proceedings, costs, charges and expenses which has been or shall or may at any time or times hereafter during the service or employment of the said _____ in such offices as aforesaid, or any such offices aforesaid, be sustained, incurred, suffered, brought, sued or commenced or paid by the Corporation by reason of any act, embezzlement, defalcation, mismanagement, neglect, failure misconduct, default, disobedience, omission, or insolvency of the said _____ or of any person or persons

acting under him or for whom he may be responsible then this above written bond/ shall be void and of no effect, otherwise the same shall be and remain in full force.

6. PROVIDED ALWAYS and it is hereby declared and agreed by and between the parties hereto that the said Collective Fidelity Guarantee Bond as aforesaid shall be and remain at the disposal of the Corporation and for pay and additional security (over and the above written bond) to the Corporation, for the indemnity and other purpose aforesaid with full power to the Corporation/ or an Officer of the Corporation duly authorized in that behalf to obtain and receive payment of the sum or sums of money recoverable or to be received upon or by virtue of the said Collective Fidelity Guarantee Bond or a sufficient portion thereof and all benefits and advantages thereof and to apply the same in and towards the indemnity as aforesaid of the Corporation or the servants of the Corporation as the case may require.
7. AND it is hereby further agreed and declared by and between the parties hereto that the said _____ shall keep the said Collective Fidelity Guarantee Bond issued by the said company in full force by payment of the premia to the Corporation in pursuance of the instructions of the Corporation as and when they fall due and by otherwise conforming to the rules of the company relating thereto.
8. PROVIDED ALWAYS that the cancellation or lapse at any time of the said Collective Fidelity Guarantee Bond shall not be deemed to affect or prejudice the right of the Corporation to take proceedings upon or under this said bond against the said company in case any breach of the condition of this bond shall be discovered after the cancellation or lapse of the said fidelity bond but the responsibility of the said _____ shall at all times continue and the Corporation shall be fully indemnified against all such loss or damage as aforesaid at any time.
9. PROVIDED FURTHER THAT nothing herein contained nor in the Collective Fidelity Guarantee Bond shall be deemed to limit the liability of the said _____ in respect of matters aforesaid to the forfeiture of the said sum of Rs. _____ (Rs. _____) or any part or parts thereof and that if the said sum be found insufficient to indemnify the Corporation in full for any loss or damage sustained by them in respect of matters aforesaid or any of them, the said _____ shall pay to the Corporation on demand such further sum as shall be deemed by the Corporation to be necessary, in addition to the said Fidelity Bond of Rs. _____ (Rs. _____) to cover such loss or damage as aforesaid and that the Corporation shall be entitled to recover such further sum payable as aforesaid in any manner open to them.

Signed and delivered by the above named _____ in the presence of : -

1. _____

2. _____

Signed for an on behalf of the Employees' State Insurance Corporation by _____ (Name) _____ (designation), being the person authorized by the Director General in that behalf in the presence of _____.

REGIONAL DIRECTOR/ MANAGER

**SCHEDULE OF AMINISTRATIVE & FINANCIAL POWERS
DELEGATED TO THE BRANCH MANAGER GRADE I & II**

Sl. No. (1)	Description of Power (2)	Extent of Power (3)
A. ADMINISTRATIVE POWERS		
BO-A.1	To act as Drawing & Disbursing Officer	Full Powers
BO-A.2	To act at 'Head of Office' in respect of the office of which he is Incharge.	Full Powers
BO-A.3	To engage a substitute in the leave vacancy of a Group 'D' employee and to pay him remuneration out of contingencies.	<p>Full powers, subject to the following conditions:</p> <p>a) The absence is for more than 5 days due to remaining on leave other than C.L.</p> <p>b) There are no leave reserve Record Sorters/ Record Sorter-cum-Peons/ Peons sanctioned for the office from which the official proceeds on leave.</p> <p>c) The substitute arrangement is made on daily wages for the periods upto and including 45 days on rates approved by the local Municipality/ State Govt. for that category of staff and in accordance with the instructions issued by the Hqrs. Office from time to time.</p>
BO-A.4	To engage part-time sweepers/ scavengers/ water carriers.	<p>Full powers subject to the conditions that part-time sweeper/ scavengers/ water carrier is engaged at the remuneration not exceeding Rs.500/- per month for Branch Office and Rs.250/- per month for Pay Office. The above rates of remuneration are maximum. The Branch Manager should not allow these rates as a matter of rule or routine unless he is satisfied with reference to locally prevalent rates, needs, area of the premises etc.</p>
BO-A.5	To appoint a substitute peon temporarily on daily wages for a period not exceeding 10 days in a month in respect of Gr.I office and 5 days in a month in respect of Gr.II office.	<p>Full powers subject to the following conditions:</p> <p>-</p> <p>1) During the period of visit of an audit party, the Record Sorter of the Branch Office is deputed to work with the audit party and the Peon of the Branch</p>

		<p>Office performs the duties of regular Record Sorter.</p> <p>2) The substitute arrangement of Peon is made on daily wages on the rates approved by the Local Body/ State Government and in accordance with the instructions issued by the Hqrs. Office from time to time.</p> <p>3) A report is sent to the Regional Director with regard to arrangement of a substitute Peon.</p>
BO-A.6	<p>To grant earned leave, half-average pay leave and commuted leave under the rules to the employees</p> <p>a) Branch Manager Gr.I</p> <p>b) Branch Manager Gr.II</p>	<p>a) Upto 30 days</p> <p>b) Upto 15 days</p> <p>- Provided no officiating arrangement is required.</p>
	<p>NOTE: In case of commuted leave, limit of 15 days means 15 un-commuted days and not 30 days commuted to 15 days.</p>	
BO-A.7	<p>i) To accept medical certificate signed by authorized medical attendant/ registered medical practitioner of Group 'C' & 'D' employees:</p> <p>a) Branch Manager Gr.I</p> <p>b) Branch Manager Gr.II</p> <p>ii) To accept in the case of female employee medical certificate from a female medical practitioner:</p> <p>a) Branch Manager Gr.I</p> <p>b) Branch Manager Gr.II</p> <p>iii) To require medical certificate of fitness before return from leave on medical grounds</p>	<p>a) Upto 30 days</p> <p>b) Upto 15 days</p> <p>a) Upto 30 days</p> <p>b) Upto 15 days</p> <p>a) Upto 30 days</p> <p>b) Upto 15 days</p>

	a) Branch Manager Gr.I b) Branch Manager Gr.II	
BO-A.8	To grant Casual Leave of more than 6 days in one spell to an employee	Full powers to be exercised only in exceptional cases and subject to report to the Regional Director.
<u>B – PAY & ALLOWANCES</u>		
BO-B.1	i) To sign pay and T.A. bills ii) To sign contingent bills iii) To act as Controlling Officer in respect of non-gazetted staff in his office, except his own, regarding grant of HRA.	Full powers Full powers provided that bills for expenditure are duly supported by sanction from the competent authority. Full powers
BO-B.2	To attest entries made in the service books of employees under his administrative control	Entries to be attested should be on the basis of orders issued by the competent authority.
BO-B.3	To sanction annual increment to all employees under him.	Full powers
BO-B.4	To sanction grant of honorarium to employee deputed on disbursement of cash benefits during the short absence of the Cashier/ Teller on leave, or visit to bank.	Rs.5/- for half day and Rs.10/- if the duly exceeds half day subject to a maximum of amount equal to the special pay sanctioned for concerned Branch Office per month.
	NOTE: As per Memo No.A-28/29/1/88-E.II (B) dated 22.4.97, special pay shall continue to be payable to regular Cashier on leave and the honorarium payable to official deputed to handle cash during the absence of Cahier will be regulated as was being done hitherto, but at enhanced rates as per Memo. <i>ibid</i>. On occasions when the regular Cashier is on duty at Pay Office for distribution of cash, the official deputed to handle cash in the Branch Office in his absence will also be entitled for honorarium.	
BO-B.5	To grant honorarium to the Peon for performing duties of a Record Sorter.	At the rate of Rs.7/- for each day for which the Peon performs the duties of a Record Sorter who is deputed with the audit party during its visit to the Branch Office, subject to, report to the Regional Director.
BO-B.6	To sanction over-time allowance to the staff: i) Branch Manager Gr.I	i) Upto Rs.150/- per month

	ii) Branch Manager Gr.II	ii) Upto Rs.75/- per month
	NOTE : Subject to the instructions issued from time to time.	
BO-B.7	To countersign as Controlling Officer, T.A. Bills for Local Committee Members.	Full Powers
BO-B.8	To sanction cycle allowance to Group 'D' employees.	Full powers upto Rs.30/- per month subject to the condition that i) the Peons own their private cycles, and do not use office cycle for any official purpose; ii) cycle allowance is admissible to one Peon/ Record Sorter-cum-Peon in each Branch Office, provided no office cycle is provided to the Branch Office.
BO-B.9	To sanction reimbursement of actual conveyance charges to the staff.	Full powers in accordance with the instructions of the Govt. Of India and provisions in SR 89 and notes thereunder to this effect.
	NOTE: The present limit for reimbursement of actual conveyance charges is Rs.150/- as per Memo to R.Ds. issued vide NO.A.28/25/2/86-Estt.II(B) dated 13/10/1986 by Hqrs. Office.	
<u>D – CONTINGENT EXPENDITURE</u>		
BO-D.1	To make purchases of stationery, rubber stamps and office equipments: i) Branch Manager Gr.I ii) Branch Manager Gr.II	i) Upto Rs.500/- at a time ii) Upto Rs.200/- at a time
	NOTE: Subject to observance of yardstick and scales prescribed by Hqrs. Office	
BO-D.2	To sanction expenditure on postage: i) Branch Manager Gr.I ii) Branch Manager Gr.II	i) Upto Rs.500/- at a time subject to budget provision. ii) Upto Rs.300/- at a time subject to budget provision.
BO-D.3	To sanction non-recurring expenditure of miscellaneous nature: i) Branch Manager Gr.I	i) Upto Rs.500/- at a time. No annual financial limit.

	ii) Branch Manager Gr.II	ii) Upto Rs.200/- at a time. No annual financial limit.
BO-D.4	<p>a) To sanction payment of water, electricity and telephone charges (excluding trunk calls) from Account No.2</p> <p>i) Branch Manager Gr.I</p> <p>ii) Branch Manager Gr.II</p> <p>b) To sanction minor repairs to phones.</p>	<p>Full powers* including STD/trunk call charges upto Rs.100/- made officially to R.O./MR Office/ RDMC Office.</p> <p>Full Powers* excluding STD/trunk call charges.</p> <p>*Subject to the following conditions:-</p> <p>i) In case where loss of rebate or any other penalty is involved, the Branch Manager may make the payment and seek ex-post-facto sanction of Regional Director with full justification/ reasons for the delay.</p> <p>iii) Submission of report to the Regional Director in respect of all the bills, in monthly statement of Account/ expenditure.</p> <p>Full powers provided the expenditure on repairs to phone is supported by a certificate that the same were necessitated due to normal wear and tear.</p>
BO-D.5	To execute on behalf of the Corporation such agreement of a normal and routine nature as has to be entered into with any appropriate authority for the use of water, electricity and telephone and for maintenance of typewriters/ computers etc.	Full powers subject to the condition that the standard terms and conditions of such agreement are first approved by the Hqrs. Office/ Regional Office, as the case may be.
BO-D.6	To sanction conveyance charges of insured persons appearing before Medical Referee for the purpose of Regulations 105 of ESI (General) Regulations, 1950.	Full powers subject to the terms and conditions laid down by Hqrs. Office from time to time.
BO-D.7	To sanction expenditure on maintenance, repair and replacement of parts of office cycle.	<p>a) Repairs upto Rs.50/- on each occasion subject to maximum of Rs.200/- in a financial year (per cycle).</p> <p>b) Replacement of parts upto Rs.100/- at a</p>

		time subject to maximum of Rs.300/- in a financial year per cycle.
	NOTE: The total expenditure on repair/ replacement of parts should not exceed 2/3rds of the cost of steel equipment in its lifetime. Thereafter the matter be referred to Regional Office for further expenditure/ orders.	
BO-D.8	To sanction expenditure on repairs of steel equipment.	Upto Rs.500/- per item & Rs.2000/- on all items in aggregate in a financial year.
	NOTE: The total expenditure on repair/ replacement of parts should not exceed 2/3rds of the cost of cycle in its lifetime. Thereafter the matter be referred to Regional Office for further expenditure/ orders.	
BO-D.9	To sanction railway/ road freight charges	Full powers provided that the normal mode of transport i.e., goods train by rail and ordinary road transport as the case may be, has been used.
BO-D.10	To sanction payment of municipal taxes in respect of buildings owned by the Corporation/ hired buildings, out of Account No.2.	<p>i) Full powers for a period not exceeding one year in respect of Branch Office building owned by the Corporation subject to submission of report to the Regional Director/ Jt. Regional Director In-charge etc. in the monthly summary of Account/ expenditure.</p> <p>iii) In respect of hired building(s) the payment of taxes is subject to the terms and conditions executed in the agreement.</p>
BO-D.11	<p>i) To sanction cost of court fee stamps, talbana and judicial papers.</p> <p>ii) Incidental court expenses.</p>	<p>i) Full powers</p> <p>ii) Upto Rs.100/- on each occasion.</p>
BO-D.12	To accept on behalf of the Corporation, security bonds furnished (fidelity bond deposited as security) by the employees of the Corporation.	Full Powers
BO-D.13	To incur expenditure for obtaining report from police/ court etc. in employment injury cases.	Full powers
BO-D.14	To sanction hot and cold weather charges.	Upto Rs.500/- at a time.

BO-D.15	To sanction expenditure on binding of declaration forms.	Upto Rs.2,000/- at a time subject to adherence to instructions issued by Hqrs. Office regarding maintenance of declaration forms.
BO-D.16	To sanction expenditure for servicing, repairs, maintenance and replacement of parts of typewriters, duplicators, calculators and computers etc.	Full powers subject to the condition that the rates are approved by the Regional Office.
BO-D.17	To sanction expenditure on repair and maintenance of furniture	Upto Rs.1,000/- at a time subject to maximum of Rs.3,000/- in a financial year.
	NOTE: Subject to (i) budget provision and (ii) the total expenditure on repairs does not exceed 2/3rds of the value of furniture in its lifetime. Thereafter, the matter may be taken up with Regional Director for sanction etc.	
BO-D.18	To sanction expenditure for purchase of general articles for office use.	Upto Rs.750/- at a time.
BO-D.19	To sanction expenditure on photographs required for identity cards or for the service books of employees.	Upto Rs.30/- in each case.
BO-D.20	To sanction expenditure on tea/ coffee and light refreshments including cold drinks etc. in connection with the meeting of Local Committees etc.	Full powers upto Rs.10/- per head per meeting subject to maximum of Rs.100/- per meeting.
BO-D.21	To sanction expenditure/ payment of fixed charges such as rent of the building from Account No.2	Full powers subject to terms and conditions and rates mentioned in the agreement and approved by the Hqrs./ Regional Director and submission of report to the Regional Director/ Jt. Regional Director Incharge etc. in the monthly summary of account/ expenditure.
E – MISCELLANEOUS		
BO-E.1	To grant advance of travelling allowance to all employees under him.	Full powers in accordance with provisions under the General Financial Rules provided the tour has been approved by the competent authority.
BO-E.2	To weed out records in accordance with the instructions issued by the Hqrs.	Full powers subject to report to the Regional Director along with the lists of records weeded out.
BO-E.3	To investigate complaints and to take necessary action thereon.	As per instructions issued from Hqrs. Office.

BO-E.4	To authorize Dy. Manager or Head Clerk in the Branch Office to exercise the powers of Branch Manager during his absence on tour/ casual leave in cases which cannot wait and are otherwise covered under the rules.	Full powers subject to instructions issued by Hqrs. from time to time in this regard. NOTE: In Branch Offices where no Head Clerk is provided/ posted, seniormost UDC may be authorized to pass payments subject to countersignature of dockets by, and <i>expost facto</i> approval of the Branch Manager on his return and communication of <i>expost facto</i> approval to Regional Director.
	NOTE: Dy. Manager in Grade-I Branch Office declared as Drawing and Disbursing Officer. However, powers are during the absence due to leave/ tour of the Manager Grade-I and a certificate to this effect to be recorded on the bills etc.	

Annexure C

FORM A – 21
(See para 14.3.7)

CERTIFICATE OF TRANSFER OF CHARGE

Certified that we have on the fore/after noon of this day respectively made over and received charge of the office of _____.

Signature of Relieved Officer
Designation

Station :
Date _____ 20

Signature of Relieving Officer
Designation

Memo of balances for which responsibility is accepted by the officer receiving charge:

Cash Balances: -

Account No. 1 _____Rs.

Account No. 2

i) In hand _____Rs.

ii) Permanent imprest with Branch Office _____Rs.

iii) Temporary advances:

(a) with Pay Office Cashier _____Rs.

(b) With Shri _____Rs.

Total _____Rs.

Permanent Imprest

a) Cash in hand _____Rs.

b) Paid Vouchers _____Rs.

c) Temporary advance with Shri _____Rs.

d) Bill No. _____ dated _____ sent to Accounts Branch
for recoupment _____Rs.

Total _____Rs.

NOTE: The total amount against (ii) above should agree with the total amount of permanent imprest held by the Branch Office.

Station :

Date _____ 20

Relieved Officer

Relieving Officer

Forwarded to _____

ABSENTEE STATEMENT
FOR THE PERIOD FROM _____ TO _____

Name of Absentee	Actual Rate of Pay	Period of Absence		Officiating employee (if any)			
		From	To	Name	Substantive Post	Substantive Pay	Officiating Pay
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Date _____ 20

Signature of Branch Manager

Annexure E

FORM A – 34
(See para 14.3.31)

REGISTER OF UNDISBURSED PAY AND ALLOWANCES ETC.

Sl. No.	Bill No.	Net amount of the bill	Date of encashment	Total amount remaining undisbursed	Particulars of the amount shown in Col.5	Dated initials of the D.D.O.	Date of Disbursement	Dated initials of the D.D.O.	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

Annexure F

**FORM A – 35
(See para 14.3.33)**

BILL REGISTER OF THE OFFICE OF _____

Bill No. & Date	Particulars of the Bill	Amount of the Bill								
		Detailed Heads of Account etc.								
		Pay	D.A.	Comp. Allowances	House rent & other Allowances	Addl. Traveling Allowances	Other items	Gross Amount	Deductions	Net Amount
		Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
(1)	(2)	(3)								

Dated initials of DDO signing the bill	Date of presentation to the Accounts Branch	Amount passed by the Accounts Branch	Date of signing acknowledgement of the receipt of cheque with initials of the officer signing the bill	Date of entry in the cash Book	Initials of the DDO Incharge of the Cash	Date of Encashment	Date of disbursement	Remarks
(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)

ABSTRACT CONTINGENT BILL
No. _____

Region	Bill for Contingent charges of	Month in which presented for payment to the Accounts Branch _____20
	* Head of Account	Voucher No. For _____ 20
Details of Nos. of Sub-Vouchers	Detailed head of charge (with description where necessary) and quotation of authority for charges requiring special sanction	Amount
	(Rs.)	(Rs.)
	Carrier over	

N.B.: The Dy. Director (F) will make payments on this form as often as required but the drawer should be careful to include in the detailed contingent bill of a month only the amount of all abstracts encashed during that month

*To be entered by Drawing and Disbursing Officer.

Details of Nos. of Sub-Vouchers	Detailed head of charge (with description where necessary) and quotation of authority for charges requiring special sanction		Amount
	Brought forward	(Rs.)	(Rs.)
	Total Rupees Deduct – Amount disallowed by the Controlling Officer in Bill No. _____ dated _____ For Rs. _____ Net amount payable (in words)		
<p>Note: The Officer drawing this bill is responsible for having initialed with date, each payment in the Contingent Register. The Register is required to be sent up with bills and sub-vouchers for the purpose. Received contents.</p> <p>Date: _____ Drawing & Disbursing Officer</p> <p>Pay Rupees () _____</p> <p style="text-align: center;">Dated _____</p> <p>Examined and entered _____ Dy. Director (Finance)</p> <p>Head Clerk</p>			

Head of Account

Objected in full pending receipt of detailed contingent bill and objected to Rs. _____ on the following grounds: -

Auditor

Head Clerk

Dy. Director (Finance)

Copy of Hqrs. Office letter No. U-16/18/1/07-Med.-I dated July 23/24,2008 to all State Governments/SSMC/SMCs/Regional Directors, etc.

Sir/Madam,

In order to improve the overall functioning of ESI Hospitals, the ESI Corporation in its 143rd meeting held on 08.07.08 has approved the constitution of Hospital Development Committees for all ESI hospitals run by the State Governments. The following functions will be looked after by the Hospital Development Committees.

- a. Such administrative and/or executive functions as may, from time to time be entrusted or delegated by the Director General.
- b. To take decisions from time to time in regard to improvements in the day to day functioning of the hospitals/ dispensaries attached.
- c. To review the availability of various facilities in the hospital/ attached dispensaries and recommend/decide up gradation of facilities for improving the delivery of health care services in the hospital/attached dispensaries.
- d. To review from time to time the working of the hospital/attached dispensaries and to decide on measures to improve administration of medical benefits and in particular strengthening of promotive and preventive health measures including occupational health services, safety and hygiene.
- e. To look after the repair and maintenance of the hospital building and buildings of the attached dispensaries.
- f. To obtain ISO Certificate for the hospitals and attached dispensaries.
- g. To look into general grievances, complaints and difficulties of insured persons and dependent patients as is considered necessary.

The committee will consist of the following persons:-

- i) Medical Superintendent -Chairman
- ii) Dy. Medical Superintendent -Convener
- iii) Employers' Representatives -Two (to be nominated by State Govt.) (locally stationed / available)
- iv) Employees' Representatives - Two (to be nominated by the State Govt.) (locally stationed / available)
- v) Staff representative -One (to be nominated by Med. Supdt.)
- vi) Representative of State Labour Dept. -One (to be nominated by State Govt.) (locally stationed / available)
- vii) Local Member(s) from ESIC/ Regional Board
- viii) Manager Branch Office, ESIC. -One (to be nominated by R.D./J.D.I/C)

2. The Committee is empowered administratively and financially to carry out the above assigned task. The committee should meet at least once in two month for reviewing the performance of the hospital/ attached dispensaries. Proper records shall be maintained of all the meetings of the Committee. The Minutes will be circulated to all members with copies to SSMC/R.D. Two Accounts in the name and style of "ESI Fund A/c No.2 – Hospital Development Committee – improvement of the Hospital" and "ESI Fund A/c No.2 – Hospital Development Committee – repairs and maintenance of the building" will be opened and initially an amount of Rs.2.00 lacs will be provided by ESIC to each of the Account to make them operational. The opening of two accounts is necessitated due to the fact that while expenditure in respect of former account is shared between ESIC and State Govt. in case of the latter the expenditure is fully met by ESIC. These accounts will be operated by the Branch Office Manager.

The Committee shall have the power of sanctioning of expenditure (other than purchase of capital equipment costing more than Rs.2.00 lacs) related to the development of the Hospital/attached dispensaries for an amount not exceeding Rs.2.00 lac per item of expenditure and total amount of the expenditure per annum should not exceed the amount indicated below.

- For the Hospital having 500 bed and above – Rs.100.00 lacs.
- For the Hospital having 200 bed and above – Rs.60.00 lacs.
- For the Hospital having 100 bed and above – Rs.40.00 lacs.
- For the Hospital having less than 100 beds – Rs.25.00 lacs.

The above amount shall not include the expenditure towards repairs and maintenance of the building.

In case the Committee considers some item of work or purchase of some equipment necessary for improving the functioning of the hospital / dispensary and such activity is beyond its power, it shall send its recommendation to SSMC/SMC to be considered separately.

3. The Hospital Development Committee will take decision in accordance with its terms of reference and its decisions will be implemented by the Medical Superintendents. Requirement of funds for implementation of decisions will be sent by Medical Superintendents directly to SSMC/SMC with a copy to Director, ESI Scheme of the State. SSMC/SMC will get the funds from the ESIC Hqrs. Office and transfer it to the accounts opened as indicated above. Payment of bills will be made by the Branch Office Manager and all bills / vouchers etc. will be kept in the Branch Office for audit / accounts purpose.
4. In case of Account related to improvement of Hospital, the total expenditure incurred though this account shall be added to the other expenditure of the Hospital and shall be sharable in the ratio of 7/8th and 1/8th between ESIC and State Govt. In case of Account relating to repairs and maintenance of hospitals the entire expenditure will be borne by ESIC.

5. As indicated above, the Hospital Development Committee will also look after the work of Repair and Maintenance of the hospital / dispensary buildings. The repair and maintenance will be done on “actual requirement” basis and not on plinth area basis. To ensure this the Medical Superintendent can take the assistance of any State Engineering department whose officers are locally available or locally available private Architect/ Engineer for preparing the estimates. Once the estimates are prepared, the work can be got executed through a State Engineering deptt./Central or State PSU as a deposit work. The work can also be got executed through private contractors following the prescribed financial rules as may be decided by the Hospital Development Committee / Medical superintendent. For capital and special repair works, the requirement will be sent to SSMC/SMC who will depute the ESIC engineer available at Regional / Sub-Regional Office for getting such works done.
6. The Regional Directors / Jt. Director (I/c) should immediately nominate the Branch Office Manager for the Hospital Development Committee. The nominated Branch Office Manager should immediately open two separate accounts as indicated above and inform the SSMC/SMC who in turn should intimate the Hqrs. Office so that funds could be transferred to operationalise the Accounts.
7. The Hospital Development Committee will start functioning immediately and they will not wait for the nomination from the State Govts. The ex-officio members, Local Member(s) from ESIC/ Regional Board, staff representative and Branch Office manager should put the Committee in motion. Other members will join the Committee as and when the State Govts. nominates them. However, the SSMC/SMC will get in touch with State Govt. to see that nominations are done as early as possible.
8. With the constitution of Hospital Development Committees all earlier Committees like Hospital Vigilance Committee etc. stand dissolved.

This issues with the approval of Director General.

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