EMPLOYEES' TRUST FUND BOARD

Application for permanent Disability Insurance Cover

For office use only

Part I [To be completed by the member]

01. I. Name of member (with initials)..

..

II Names denoted by initials ....

..

02. Address :..

..

03. (i) Age:.................................. (ii) Date of Birth:...

04. National Identity Card No :...

05. Employer's name & Address:...

..

06. I. EPF/PPF Number of Employer:..

II. Membership No:......................................

07. Date of joining the establishment;..

08. Details of Bank Account : (i) Name of Bank ....

(ii) Bank Branch ....

(iii) Account No ....

09. Date of Accident/Commencement of Illness:...

10. Nature of Accident /Illness :..

11. Date of admission to Hospital ;..

12. Date of discharged from Hospital;...

13. Name of hospital to which you were admitted:...

...

14. Have you become permanently disabled as a result of the accident;

..

If so the effective date of disability as recommended by the Medical Officer.

..

15. Date of loss of employment due to permanent disability:..................................

I do hereby declare that the foregoing facts are true and correct. I am aware that I shall be liable for prosecution in a Court of Law if I have furnished any false information.

Thumb impressions of member:

Left Right **...**

Signature of Member

Date ;...........................

Telephone No:............................

<u>Part 2</u> **[To be completed by the employer]**

01. I, the manager / Administrator / proprietor* of...

(name of establishment)

...at ....

(address)

..hereby certify that Mr/Mrs/Miss*

..

(name of member)

bearing EPF/PPF No..................................... and having NIC No................................

has been serving in this establishment and that his/her* services were

terminated as he/she* has become permanently disabled owing to.............................

..

..From...

02. We further certify that we have remitted ETF contributions on behalf of this employee continuously up to the date his / her* services were terminated [as referred to in 1 above] to the ETF Board, and that he / she is no longer employed in our establishment. Details of contributions remitted and salary paid to him/her8 for the twelve months prior to the month in which he/she8 became disabled are given below:

Month	Salary	Contribution

03. In addition to above, we give below the details of ETF contributions remitted in respect of all our employees, during the above mentioned twelve months;

Month	Total Contribution paid to ETF	Date of Payment	Cheque No.

04. Whether contributions for the above period were made through Form R1 or Form R4:...

05. If contributions are remitted through Form R1, Form II returns for the relevant period [please tick relevant cage]:

i) Have already been sent to the ETF and his / her* name has been included in the return: ☐

ii) Is to be sent in due course and his/her* name will be included in the return. ☐

I do hereby declare that the foregoing facts are true and accurate. I am aware that if I furnish any false information I shall be liable for prosecution in a Court of Law under Section 39 of the Employees' Trust Fund Act.

Date;..................................

..
Signature of Employer

Seal
Tel.no.

*Please delete whichever is inapplicable

EMPLOYEES' TRUST FUND ACT NO. 46 of 1980
Medical Certificate

To: The Chairman, Employees' Trust Fund board, Colombo 5

I, ...being a registered Medical Practitioner bearing Registration No.........................do hereby declare that I have this...day of ....20...........examined

....

[name of patient]

who is a member of the Employees' Trust Fund and I certify that the said..........................

....is suffering from...

.... and in consequence permanently and totally incapacitated and unfit for work any longer. The percentage of disability is ....%.

The said...placed

his/her signature and thumb marks on this certificate in my presence.

Thumb marks of member:

Left Right

....
Signature of Member

....
Signature of Medical practitioner

Date ;.........................

Seal :

Telephone No: