

EMPLOYEES' TRUST FUND BOARD

**Application for Re-imbusement of Cost of
Intra – ocular Lens**

For Office Use

Part I (To be filled by the Member)

- 01. (i) Name of Member (with initials:
.....
- (ii) Names denoted by initials :
- (iii)

- 02. Address:.....
.....

- 03. (i) Age:..... (b) Date of Birth :.....

- 04. National Identity Card Number :.....

- 01.** Employer's Name & Address:
.....

- 06. (i) Employer's EPF/PPF Number :.....
(ii) Membership Number:

- 07. Date of joining the establishment:.....

- 08. Nature of Employment :

- 08.** Particulars of Bank Account :.....
(i) Name of Bank :.....
(b) Bank Branch :.....
(c) Account Number :.....

- 09.** Details about surgery to remove the cataract:.....
- (c) Hospital in which surgery has been performed :.....
- (ii) Date of Admission to Hospital :.....
- (iii) Date of discharged :.....
 (A copy of the diagnosis ticket certified by the employer should be attached)
- 10.** Place from where intra-Ocular Lens was purchased and date:.....

- 11.** Cost of the Intra-Ocular lens Rs.:.....

- 12.** Amount paid by the establishment where the member is employed for the Intra-
 Ocular lens ; Rs.....

I certify that the particulars forwarded above are true and accurate. I am aware that action can be filed against me in a Court of Law if I furnish false information.

Thumb Impressions:

Left

Right

.....
 Signature of Member

Date :.....

Telephone no;.....

Part II (To be certified by the Medical Officer)

I hereby certify that Mr/Mrs/Miss ;.....entered hospital onto undergo surgery for the removal of a cataract, and that the operation and the implanting of the lens were done onand that he/she was discharged from hospital on

Date :

.....
**Name / Signature and Seal of
the Medical Officer**

Part III : (To be completed by the Employer)

01. IManager / Administrator / Owner ofat
(Name of the Establishment)
.....do
hereby certify that Mr/ Mrs/Miss
(Name of Member)
.....
bearing EPF/PPF Number and National Identity Card
No. is serving in this establishment from
..... to date.

02. We further certify that we have remitted ETF contributions on his/her behalf continuously and that he/she continues to be employed in our establishment. Details of contributions deposited on his/her behalf for the twelve (12) months prior to the month in which the surgery was/ is to be performed are given below:

Month						
Contribution						

Month						
Contribution						

03. In addition to the above we give below details of ETF contributions remitted in respect of all our employees during the above mentioned twelve (12) 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 return for the relevant period. (please tick relevant cage)

(a) Has already been sent to the ETF and his/her name has been included in the return.

(b) Is to be sent in due course and his/her name will be included in the return.

06. Out of the total cost incurred by Mr / Mrs./Miss.....
who is an employee of this organization, for purchasing the Intra Ocular Lens, our organization has paid/has agreed to pay Rs. / will not make any payments.

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;

Telephone No:.....