

| INVESTMENT DECLARATION COVER LETTER : FINANCIAL YEAR 2022-23 | | | |
|---|---|---|---|
| Income Tax deductible shall be calculated based on this information | | | |
| Employee ID | | | |
| Employee Name | | | |
| PAN | | | |
| Address | | | |
| HRA Exemption U/s 10(13A): | | | |
| | Period | Amount | |
| House Rent | Apr-22 | | Please note that original rent receipts or documents has to be submitted along with the copy of Rental Agreement at the time of collection of Investment declared if rent paid is more than Rs. 1,00,000. |
| | May-22 | | |
| | Jun-22 | | |
| | Jul-22 | | |
| | Aug-22 | | |
| | Sep-22 | | |
| | Oct-22 | | |
| | Nov-22 | | |
| | Dec-22 | | |
| | Jan-23 | | |
| | Feb-23 | | |
| | Mar-23 | | |
| | TOTAL | - | |
| If rent declared is more that 8,300/- per month then, employee have to provide below Landlord details | | | |
| Name of the owner: | | | |
| Residential address: | | | |
| PAN of the owner: | | | |
| Deduction Under Chapter VI A | | | |
| | Particulars | Maximum Allowable | Amount |
| Deduction Under Chapter VI A | Sec 80D - Medical Insurance Premium - | 25,000 | |
| | Sec 80D - Medical Insurance Premium - parents | 25,000 | |
| | Sec 80D - Medical Insurance Premium - parents are senior citizens (above 60 years) | 50,000 | |
| | Sec 80DD - Medical treatment of handicapped dependant Rs. 50K, If severe - 125k | 125,000 | |
| | Sec 80DDB - Medical treatment of dependent (specified diseases only) Rs.40K, 60K if dependent is a senior citizen | 100,000 | |
| | Sec 80E - Interest paid on Education loan for higher education of self/spouse/children (only Interest component) | Actual Interest paid during the year upto 7 years from the date of loan | |
| | Sec 80U - Handicapped Rs.75 K (if severely Handicapped Rs.125K) | Rs.125,000 | |

| Tax Exemption under Sec 80C | | | |
|--|---|--------------|--------|
| | Particulars | Max Limit | Amount |
| Section 80CCC | Contribution to Pension Fund | Rs. 1,50,000 | |
| Section 80C | Employee PF deducted from your salary: | | |
| | Voluntary PF deducted from your salary: | | |
| | Life Insurance Premium | | |
| | Deferred Annuity | | |
| | Public Provident Fund | | |
| | Post Office time deposit - 5 years and above only | | |
| | ULIP of UTI/LIC | | |
| | Principal Loan (Housing Loan) Repayment, stamp duty, registration fees paid | | |
| | Mutual Funds (ELSS with lock in of 3 years) | | |
| | Children-Tuition Fee - Restricted to a max of 2 children | | |
| | Sukanya Samridhi Account Benefit for Girl Child below 9 yrs | | |
| | Deposit in NHB | | |
| | Deposit in NSC | | |
| | Interest on old Deposit in NSC (this amt will be considered as income as well as considered as deduction u/s 80C) | | |
| Section 80CCD (1B) | Contribution to Govt recognized Pension schemes like NPS | Rs. 50,000 | |
| Please note: Your employee PF and VPF that are deducted from your salaries are also part section 80C and is a part of above ceiling limit of Rs. 1.5 Lakh, please also note, employer PF is not part of 80 C | | | |
| Details of Income Other than Salary | | | |
| | Particulars | Max Limit | Amount |
| | Other Income (mention source in particulars) | No Limit | |
| | Interest on house loan (mention Bank name in particulars) | (200,000) | |

If Employed with a concern other than current organisation during the year (from April 2022 to the date of joining current organisation and not before)

| | Particulars | Amount |
|---|--------------------------------------|--------|
| Previous Employment Salary (Salary earned from 01/April/2022 till joining present co.) and not last years | Taxable income before profession tax | |
| | Profession tax amount deducted | |
| | EPF deducted | |
| | TDS deducted | |

Declaration:

- 1) I hereby declare that the information given above is correct and true in all respects.
- 2) I also undertake to indemnify the company for any loss/liability that may arise in the event of the above information being incorrect.

Date :

Place: Bangalore

Signature of the

Employee:



EMPLOYEES PROVIDENT FUND ORGANIZATION
Employees provident funds scheme, 1952 (paragraph 34 & 57) &
Employees pension scheme 1995 (paragraph 24)

New Form No.11- Declaration Form
(To be retained by the employer for future reference)

Emp Code: _____

Company: _____

(Declaration by a person taking up employment in any establishment on which EPF Scheme, 1952 and /of EPS1995 is applicable)

| | | | | | | |
|----|---|-----|--------------------------|----------|--------------------------|--------|
| 1 | Name of the member | | | | | |
| 2 | Father's Name () Spouse's Name () (Please Tick Whichever Is Applicable) | | | | | |
| 3 | Date of Birth (DD/MM/YYYY) | | | | | |
| 4 | Gender: (male / Female / Transgender) | | | | | |
| 5 | Marital Status (married /Unmarried /widow/divorce) | | | | | |
| 6 | (a)Email ID: | | | | | |
| | (b)Mobile No: | | | | | |
| 7* | Whether earlier a member of Employees 'provident Fund Scheme 1952 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| 8* | Whether earlier a member of Employees 'Pension Scheme ,1995 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| | If response to any or both of (7) & (8) above is yes. MANDATORY FILL UP THE (COLUMN 9) | | | | | |
| 9 | a) Universal Account Number(UAN) | | | | | |
| | b) Previous PF a/c No | AP | HYD | EST.CODE | EXTN | PF NO. |
| | c) Date of exit from previous employment (DD/MM/YYYY) | | | | | |
| | d) Scheme Certificate No (if Issued) | | | | | |
| | e) Pension Payment Order (PPO)No (if Issued) | | | | | |
| 10 | a) International Worker: | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| | b) If Yes , State Country Of Origin (India /Name of Other Country) | | | | | |
| | c) Passport No | | | | | |
| | d) Validity Of Passport (DD/MM/YYYY) to(DD/MM/YYYY) | | | | | |
| 11 | KYC Details: (attach Self attested copies of following KYCs) ** | | | | | |
| | a) Bank Account No .& IFS code | | | | | |
| | b) AADHAR Number (12 Digit) | | | | | |
| | c) Permanent Account Number (PAN),If available | | | | | |

UNDERTAKING

- 1) Certified that the Particulars are true to the best of my Knowledge
 - 2) I authorize EPFO to use my Aadhar for verification / e KYC purpose for service delivery
 - 3) Kindly transfer the funds and service details, if applicable if applicable, from the previous PF account as declared above to the present P.F Account(The Transfer Would be possible only if the identified KYC details approved by previous employer has been verified by present employer
 - 4) In case of changes In above details the same Will be intimate to employer at the earliest
- Date: _____
Place: _____

Signature of Member

DECLARATION BY PRESENT EMPLOYER

- A) The member Mr./Ms./Mrshas joined onand has been allotted PF Number.....
- B) In case person was earlier not a member of EPF Scheme ,1952 and EPS,1995
- (Post allotment of UAN) The UAN Allotted for the member is.....
 - Please tick the Appropriate Option:
 - The KYC details of the above member in the UAN database
 - ☐ Have not been uploaded
 - ☐ Have been uploaded but not approved
 - ☐ Have been uploaded and approved with DSC
- C) In case the person was earlier a member of EPF Scheme ,1952 and EPS, 1995:
- The above PF account number /UAN of the member as mentioned in (a) above has been tagged with his /her UAN/previous member ID as declared by member
 - Please Tick the Appropriate Option
 - ☐ The KYC details of the above member in the UAN database have been approved with digital signature Certificate and transfer request has been generated on portal.
 - ☐ As the DSC of establishment are not registered With EPFO the member has been informed to file physical claim (Form13) for transfer of funds from his previous establishment.

Date

Signature of Employer With seal of Establishment



DIRECT DEPOSIT AUTHORIZATION AGREEMENT
India

This form gives Fastenal and your financial institution authority to deposit your pay into your bank account. Your pay will automatically be credited to your personal checking or savings account each payday. You will receive a paycheck "stub" to reflect your earnings information. If payday falls on a weekend or holiday, your funds will be deposited on the previous banking business day.

It is your responsibility to notify the payroll department if any changes occur in your financial institution information.

EMPLOYEE INFORMATION


| | | | |
|------------------------|---------------|-------------------|---------------|
| <u>VISHESH SINGHAL</u> | FT/ PT | <u>MNNPS3133C</u> | <u>176185</u> |
| Name on Bank Account | Circle One | PAN | Employee ID |

FINANCIAL INSTITUTION INFORMATION

| | | | |
|---------------------------------|-------------------------------------|--------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | | |
| Checking or Savings (check one) | | | |
| <u>ICICI BANK</u> | | | |
| Bank Name | | | |
| <u>BANGALORE</u> | | | |
| Bank City | | | |
| <u>142201549527</u> | | | |
| Account Number | | | |
| <u>ICICINBB</u> | | <u>ICIC0001422</u> | |
| Swift Code | | IFSC Code | |

I hereby authorize Fastenal to initiate credit entries to my account.

This authority is to remain in full force and effect until the company has received written notification from me on its termination in such time and manner as to afford the company reasonable time to act on it.

| | |
|---|-------------------------------------|
|  _____ Signature | <u>02 JAN 2024</u> _____ Date |
|---|-------------------------------------|

DO NOT SEND A CHECK OR DEPOSIT SLIP.

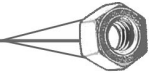
You must call your financial institution to verify the banking information supplied above is accurate.

Sign completed form and Email to payrollindia@fastenal.com
or Fax to 507-453-8078.

| | |
|---------------------|--|
| For Office Use Only | |
| Processed By _____ | |
| Date _____ | |

Fastenal Policy Acknowledgement

India



Section 2 of the new employee packet contains Fastenal's Policies and Procedures.

I, the undersigned, have read, understand, and will comply with the obligations outlined in the Policies and Procedures listed below.

Policy/Procedure

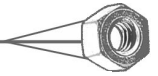
| | |
|--|--|
| Auto Accident/Damage Procedure | Equal Employment Opportunity |
| Business Across Borders | Environment, Health, Safety and Sustainability |
| Cash Drawer | Information Technology Acceptable Use |
| Complaint Procedure for Financial, Accounting and Auditing Matters | Leave Policies |
| Complaint Procedure for Wage/Payroll | Light Duty Work |
| Confidentiality and Securities Trading | Personnel Records |
| Confidentiality Statement | Standards of Conduct |
| Credit and Collections | Use of Copyrighted Materials |
| Driver's License Procedure | Vehicle |
| Drug-Free Workplace | Work Related Injuries |
| Earned Leave (Vacation) | |

The Company reserves the right to modify, add to, or eliminate any of the policies in the employee packet at any time, at its discretion and without notice.

Your acknowledgement will continue to apply to any revised or updated information contained within the respective policy.

| | |
|------------------------------------|-------|
| Date: | _____ |
| Print Name: | _____ |
| Signature: | _____ |
| Date of Birth: | _____ |
| Country: | _____ |
| Distribution Center/Branch: | _____ |

Health Insurance Enrollment Form



EMPLOYER USE ONLY

EMP ID: _____ FT DATE: _____ NEW: _____ CHANGE: _____ EFF DATE: _____
COUNTRY: _____ PLAN: _____

Group Health Insurance Enrollment/Waiver Form

Instructions:

If electing insurance, complete Box 1. If declining insurance, complete Box 2.

Enrollment of Health Insurance Coverage

Box 1

Details of Employee/Insured Member (please print/sign in English only)

Legal Name (first/last): _____ English Name (if applicable): _____

Address: _____

Date of Birth: _____ Gender: _____ Branch/Dept: _____
MONTH DAY YEAR

Dependent Information (for Insured member's Dependent(s), if applicable)

| | Name (first/last) | Gender | Date of Birth (mm/dd/yy) | Relationship |
|----|-------------------|--------|--------------------------|--------------|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |

Authorization of Coverage

By signing below, I understand that I am enrolling in a group health insurance plan. The health insurance premiums for the employee, spouse and up to 2 children are 100% employer paid. Premiums for parents are paid on a cost share basis and the employee is responsible to pay 390 rupees per parent (2 max) per month. Note: in-laws and siblings are not eligible dependents.

Signature: _____ Date: _____

Waiver of Health Insurance Coverage

Box 2

This waiver must be completed only in the case that you do NOT want coverage.

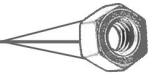
I have been informed that I am eligible for health coverage through my employer and have decided to decline participation.

Legal Name (first/last): _____ English Name (if applicable): _____

Signature: _____ Date: _____

Rev. 2/2022

Human Resources Information Form



India

Branch (5) / Dept:

Legal Name

Given Name

Surname

ADDRESS

Address 1:

Address 2:

Address 3:

Locality:

Province:

Postal:

Country:

PAN:

AAAAA9999A

Gender:

Male

Female

Place X in Box.

Date of Birth:

(dd/mm/yy)

Signature

Date

Driver Eligibility Acknowledgement Form

It is Company policy to ensure that employees driving vehicles for business purposes are licensed and insurable. Only employees who maintain a valid, unrestricted driver's license will be permitted to drive a vehicle for Company business.

Please complete the below form indicating the current status of your state/province/country driver's license and your acknowledgement of your eligibility or ineligibility to operate a vehicle for Company business.

NOTE: The following form is required for all employees, even those whose regular job duties do not include the operation of a vehicle for Company business.

Employee ID

Name

Location

☐ **OPTION #1: I do not have a valid, unrestricted driver's license.**

By selecting this option I acknowledge that I am not permitted, under any circumstances, to operate a vehicle for business purposes.

☐ **OPTION #2: I have a valid driver's license with the following restriction(s).**

By selecting this option I acknowledge that I am legally eligible to operate a motor vehicle but only when the following restrictions are met.

Restriction(s):

☐ **OPTION #3: I have a valid, unrestricted driver's license.**

By selecting this option I acknowledge that I am legally eligible to operate a motor vehicle with no restrictions.

If you selected Option #2 or Option #3, please enter your driver's license information below AND submit a photocopy of the front and back of your driver's license card to the Insurance Department via email (insurancemvr@fastenal.com) or fax (507-494-9802).

Driver's License Number

State / Province Issued

Country Issued

By my signature I acknowledge that the above information is complete and accurate to the best of my knowledge.

Signature

Date

Please submit completed form via fax (507-494-9802) or email (insurancemvr@fastenal.com).