

Emp Code: Locked for Employee

Mob No.: Auto Linked

Form 'F'

[See sub rule (1) of Rule 6] **Nomination**

To:

Ciel HR Services Pvt Ltd

1. I Shri/ Shrimati/ Kumari Auto Linked
(Name in full)

Whose particulars are given in the statement below, hereby nominate the person(s) mentioned below to receive the gratuity payable after my death as also the gratuity standing to my credit in the event of my death before that amount has become payable, or having become payable has not been paid and direct that the said amount of gratuity shall be paid in proportion indicated against the name(s) of the nominee(s).

2. I hereby certify that the person(s) mentioned is/are members of my family within the meaning of clause (h) of section 2 of the payment of Gratuity Act, 1972.
3. I hereby declare that I have no family within the meaning of clause (h) of section 2 of the said Act.
4. (a) My Father /Mother Parents is/are not dependent on me.
(b) My Husband's Father /Mother /Parents is /are not dependent on my husband.
5. Nomination made herein invalidates my previous nomination

Nominee(s)

Name in full with Full address of nominee's	Relationship with the Employee	Age of Nominee	Proportion by which the gratuity will be shared (%)
Auto Linked and based on the nomination accordian			

Emp Code: Locked for Employee

Mob No.: Auto Linked

Statement

1. Name of employee in full : Auto Linked
2. Sex : Auto Linked
3. Religion : Auto Linked
4. Whether unmarried /married /Widow/Widower : Auto Linked
5. Department /Branch/ Section where employed :
6. Post held with ticket of Serial No. if Any :
7. Date of appointment : Auto Linked based on AL
8. Permanent Address : Auto Linked

Village _____ Thana _____
Sub-Division _____ Post Office _____
District _____ State _____

Place: Auto Linked

Date: Auto linked based on complition of Onboarding

Need a field for Employee to upload signature

Signature/thumb-impression of the employee 

Declaration by witnesses

Nomination signed/thumb impressed before me.

Name in full and full address of witnesses

Signature of witnesses

1.

1.

2.

2.

Place:

Date:

Certificate by the employer

Certified that the particulars of the above nomination have been verified and recorded in this establishment.

Employer's Reference No. if any.

Signature of the employer/officer authorised

Designation:

CIEL HR Services Private Limited

No. 2802 (Broadway Building)

2nd Floor, 27th Main Road

HSR layout, Sector 1,

Bengaluru, Karnataka - 560 102.

Date:

Acknowledgement by the employee

Received the duplicate copy of nomination in Form 'F' filed by me and duly certified by the employer.

Date:

Locked for Employee
Signature of the employee 

Note: Strike out the words and paragraphs not applicable



Composite Declaration Form -11
(To be retained by the employer for future reference)

EMPLOYEES' PROVIDENT FUND ORGANISATION

Employees' Provident Funds Scheme, 1952 (Paragraph 34 & 57) &

Employees' Pension Scheme, 1995 (Paragraph 24)

(Declaration by a person taking up employment in any establishment on which EPF Scheme, 1952 and /or EPS, 1995 is applicable)

1	Name of the member	Auto Linked																
2	Father's Name <input type="checkbox"/> Spouse's Name <input type="checkbox"/>	Auto Linked																
3	Date of Birth: (DD/ MM / YYYY)	Auto Linked																
4	Gender: (Male/Female/Transgender)	Auto Linked																
5	Marital Status: (Married/Unmarried/Widow/Widower/Divorcee)	Auto Linked																
6	(a) Email ID: (b) Mobile No.:	Auto Linked Auto Linked																
7	Present employment details: Date of joining in the current establishment (DD/MM/YYYY)	Auto Linked Based on AL Generation																
8	KYC Details: (attach self attested copies of following KYCs) a) Bank Account No. : b) IFS Code of the branch: c) AADHAR Number d) Permanent Account Number (PAN), if available	Auto Linked Auto Linked Auto Linked Auto Linked																
9	Whether earlier a member of Employees' Provident Fund Scheme, 1952	Yes/No Tick Box for Employee																
10	Whether earlier a member of Employees' Pension Scheme, 1995	Yes/No Tick Box for Employee																
11	Previous employment details: [if Yes to 9 AND/OR 10 above] - Un-exempted <table border="1"> <thead> <tr> <th>Establishment Name & Address</th> <th>Universal Account Number</th> <th>PF Account Number</th> <th>Date of joining (DD/MM/YYYY)</th> <th>Date of exit (DD/MM/YYYY)</th> <th>Scheme Certificate No. (if issued)</th> <th>PPO Number (if issued)</th> <th>Non Contributory Period (NCP) Days</th> </tr> </thead> <tbody> <tr> <td colspan="8">Text Bok to fill the required Details</td> </tr> </tbody> </table>		Establishment Name & Address	Universal Account Number	PF Account Number	Date of joining (DD/MM/YYYY)	Date of exit (DD/MM/YYYY)	Scheme Certificate No. (if issued)	PPO Number (if issued)	Non Contributory Period (NCP) Days	Text Bok to fill the required Details							
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Text Bok to fill the required Details																		
12	Previous employment details: [if Yes to 9 AND/OR 10 above] - For Exempted Trusts <table border="1"> <thead> <tr> <th>Name & Address of the Trust</th> <th>UAN</th> <th>Member EPS A/c Number</th> <th>Date of joining (DD/MM/YYYY)</th> <th>Date of exit (DD/MM/YYYY)</th> <th>Scheme Certificate No. (if issued)</th> <th>Non Contributory Period (NCP) Days</th> </tr> </thead> <tbody> <tr> <td colspan="7">Text Bok to fill the required Details</td> </tr> </tbody> </table>		Name & Address of the Trust	UAN	Member EPS A/c Number	Date of joining (DD/MM/YYYY)	Date of exit (DD/MM/YYYY)	Scheme Certificate No. (if issued)	Non Contributory Period (NCP) Days	Text Bok to fill the required Details								
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Text Bok to fill the required Details																		
13	a) International Worker:	Yes/No Tick Box for Employee																
	b) If yes, state country of origin (India/Name of other country)	NA if tick box is no, Text box to edit details if Tick box is Yes																
	c) Passport No.	NA if tick box is no, Text box to edit details if Tick box is Yes																
	d) Validity of passport [(DD/MM/YYYY) to (DD/MM/YYYY)]	NA if tick box is no, Text box to edit details if Tick box is Yes																

UNDERTAKING

- 1) Certified that the particulars are true to the best of my knowledge.
- 2) I authorize EPFO to use my Aadhar for verification/authentication/e-KYC purpose for service delivery.
- 3) Kindly transfer the funds and service details, if applicable, from the previous PF account as declared above to the present P.F. Account as I am an Aadhar verified employee in my previous PF Account. *
- 4) In case of changes in above details, the same will be intimated to employer at the earliest.

Date:

Place:

Need a field for Employee to upload signature

Signature of Member 

DECLARATION BY PRESENT EMPLOYER

A. The member Mr/Ms/Mrs Auto Linked has joined on
and has been allotted PF No and UAN

B. In case the person was earlier not a member of EPF Scheme, 1952 and EPS, 1995:

☐ **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/e-sign.

C. In case the person was earlier a member of EPF Scheme, 1952 and EPS, 1995:

☐ **Please Tick the Appropriate Option:-**

- ☐ The KYC details of the above member in the UAN database have been approved with E-sign/Digital Signature Certificate and transfer request has been generated on portal.
- ☐ The previous Account of the member is not Aadhar verified and hence physical transfer form shall be initiated.

Locked for Employee

CIEL HR Services Private Limited
No. 2802 (Broadway Building),
2nd Floor, 27th Main Road
HSR Layout, Sector 1,
Bengaluru, Karnataka - 560 102.

Date: **Locked for Employee**

Locked for Employee
Signature of Employer with seal of
Establishment

* Auto transfer of previous PF account would be possible in respect of Aadhar verified employees only. Other employees are requested to file physical claim (Form-13) for transfer of account from the previous establishment.

**FORM - 2 (Revised)**Emp Code: **Locked for Employee**Mob No.: **Auto Linked****NOMINATION AND DECLARATION FORM
FOR EXEMPTED / UNEXEMPTED ESTABLISHMENTS**

Declaration and Nomination Form Under the Employee's Provident Funds & Employees' Pension Scheme

(Paragraph 33 & 61 (1) of the Employees' Provident Fund Scheme, 1952 & Paragraph 18 of the Employees' Pension Scheme, 1995)

i.	Name (In Block Letters)	:	Auto Linked but in BLOCK Letters
ii.	Father's / Husband's Name	:	Auto Linked
iii.	Date of Birth	:	Auto Linked
iv.	Sex	:	Auto Linked
v.	Marital Status	:	Auto Linked
vi.	Account Number	:	Auto Linked based in UAN Generation and locked for Employee
vii.	Address i. Permanent	:	Auto Linked
	ii. Temporary	:	Auto Linked
viii.	Date of Joining	:	Auto Linked based in AL Generation
ix.	i. EPF	:	
	ii. EPS	:	

PART- A (EPF)

I hereby nominate the person(s) / cancel the nomination made by me previously and person(s) mentioned below to receive the amount standing to my credit in the Employees' Provident Fund, in the event of my death.

Name & Address of the Nominee/ Nominees	Nominee's relationship with the member	Date of Birth	Total amount of share of accumulation in provident fund to be paid to each nominee	If the nominee is minor name, address & relationship of the guardian who may receive the amount
1	2	3	4	5
Auto Linked and based on the nomination accordian				

Certified that I have no family as defined in para 2 (g) of the Employee's Provident Fund Scheme 1952 and should I

1. Acquire a family hereafter the above nomination should be deemed as cancelled
2. Certified that my father / mother is / are depended upon me
3. Unmarried members in the absence of dependent parents may nominate any other person to receive the shares

Note: A Fresh nomination shall be made by the member on his/her marriage and any nomination made before such marriage shall be deemed to be invalid

Need a field for Employee to upload signature

Signature or thumb impression of the Subscriber

PART - B (EPS)

I hereby furnish below particulars of the members of my family who would be eligible to receive widow/children pension in the event of my death

S.No	Name of the Family Members	Address	Date of Birth	Relationship
1	Auto Linked and based on the nomination accordian			
2				
3				
4				
5				


Certified that I have no family as defined in para 2 (vii) of the Employee's Pension Scheme 1995 and should I acquire a family hereafter the above nomination should be deemed as cancelled

I hereby nominate the following person for receiving the monthly widow pension (admissible under para 16(2) (g) (i) & (ii) in the event of my death without leaving any eligible family member for receiving pension.

Name & Address of the Nominee	Date of Birth	Relationship with the member
Auto Linked and based on the nomination accordian		

Need a field for Employee to upload signature

Date:

Signature / Thumb impression of the subscriber 

CERTIFICATE BY EMPLOYER

Certified that the above declaration and nomination has been signed/thumb impressed before Shri/Smt/Kum employed in my establishment after he/she has read the entry/entries have been read over to him/her by me and got confirmed by him/her.

Place:

Date :

Locked for Employee

Signature of the employer

CIEL HR Services Private Limited
No. 2802 (Broadway Building)
2nd Floor, 27th Main Road
HSR Layout, Sector 1,
Bengaluru,
Karnataka – 560102



घोषणा पत्र DECLARATION FORM

फार्म-1/Form-1

घोषणा पत्र कर्मचारी द्वारा भरा जाएगा। फार्म के साथ पोस्टकार्ड आकार के दो फोटोग्राफ भी लगाए जाने चाहिए। फार्म भरने से पहले पीठ पृष्ठ पर दी गई हिदायतों को भली-भांति पढ़ लेना चाहिए। यह फार्म नि:शुल्क है।

To be filled by employee after reading instruction overleaf. Two Postcard Size photographs to be attached with the form. This form is free of cost.

(क) बीमाकृत व्यक्ति के विवरण

(A) INSURED PERSON'S PARTICULARS

1. बीमा संख्या/Insurance No.				
2. नाम (स्पष्ट अक्षरों में) Name in block letters	Auto Linked but in BLOCK Letters			
3. पिता/पति का नाम Father's/Husband's Name	Auto Linked			
4. जन्म की तिथि Date of Birth	दिन Day	महीना Month	वर्ष Year	5. वैवाहिक प्रास्थिति Marital Status
	Auto Linked			विवाहित/अविवाहित M/U/W
				6. लिंग/Sex पु.म./M.F.
7. वर्तमान पता/Present Address	8. स्थायी पता/Permanent Address			
Auto Linked	Auto Linked			
पिन कोड Pin Code	पिन कोड Pin Code			
टेलीफोन नम्बर/ई-मेल पता/ Branch Office	टेलीफोन नम्बर/ई-मेल पता/ Dispensary			

(ख) नियोजक के विवरण

(B) EMPLOYER'S PARTICULARS

9. नियोजक की कूट संख्या Employer's Code No.	Auto Linked based on AL Generation		
10. नियुक्ति की तारीख Date of Appointment	दिन Day	महीना Month	वर्ष Year
	Auto Linked based on AL Generation		
11. नियोजक का नाम और पता/Name & Address of the Employer			
12. यदि पहले नियोजन में रहे हैं तो कृपया निम्नलिखित ब्यार दोजिए In case of any previous employment please fill up the details as under.			
(क) पिछली बीमा संख्या (a) Previous Ins. No.			
(ख) नियोजक कूट संख्या (b) Employer's Code No.			
(ग) नियोजक का नाम व पता (c) Name & Address of the Employer			
टेलीफोन नम्बर/ई-मेल पता/e-mail address			

(क) मृत्यु की स्थिति में नकद हितलाभ के भुगतान के लिए क.रा.बी. अधिनियम, 1948 की धारा 71/क.रा.बी. (केन्द्रीय) नियम, 1950 के नियम 56(2) के अंतर्गत नामित के ब्यारे।
(c) Details of Nominee u/s 71 of ESI Act 1948/Rule-56(2) of ESI (Central) Rules, 1950 for payment of cash benefit in the event of death.

नाम/Name	नातेदारी/Relationship	पता/Address
Auto Linked		

मैं एतद्वारा घोषणा करता/करती हूँ कि मेरे द्वारा प्रस्तुत किए गए विवरण मेरी जानकारी और विश्वास के अनुसार सही हैं। मैं अपने परिवार के सदस्यों में हुए परिवर्तन की सूचना 15 दिन के भीतर प्रस्तुत करने का वचन भी देता हूँ/देती हूँ।

I hereby declare that the particulars given by me are correct to the best of my knowledge and belief. I undertake to intimate the corporation any changes in the membership of my family within 15 days of such change.

Need a field for Employee to upload signature

नियोजक के प्रतिहस्ताक्षर
Counter signature by the employer

बीमाकृत व्यक्ति के हस्ताक्षर/अंगुली निशान
Signature /T.I. of I.P.

सील सहित हस्ताक्षर

Signature with seal

(घ) बीमाकृत व्यक्ति के परिजनों का विवरण

(D) Family Particulars of Insured person

क्र.सं. Sl. No.	नाम Name	फार्म भरने की तारीख को आयु/जन्म-तारीख Date of Birth/Age as on date of filling form	कर्मचारी के साथ नातेदारी Relationship with the Employee	क्या उनके साथ रह रहे हैं? बताएं Whether residing with him/her.		यदि नहीं तो आवास का स्थान दर्शाएं If 'No' state Place of Residence	
				हाँ/Yes	नहीं/No	कस्बा/Town	राज्य/State
	Auto Linked						

क.रा.बी. निगम अस्थायी पहचान पत्र
ESI Corporation Temporary Identity Card

(नियुक्ति की तारीख से 3 महीने तक वैध)

(Valid for 3 month from the date of appointment)

नाम/Name	
बीमा संख्या/Ins. No.	नियुक्ति की तारीख/Date of appointment
शाखा कार्यालय Branch Office	औपचारिक Dispensary
नियोजक की कूट संख्या व पता Employer's Code No. & Address	

Need a field for Employee to upload Photo
(Space for photograph)

वैधता
Validity
तारीख
Dated

Need a field for Employee to upload signature

बीमाकृत व्यक्ति के हस्ताक्षर/अंगुली निशान
Signature/T.I. of I.P.

सील सहित शाखा प्रबंधक के हस्ताक्षर
Signature of B.M. with seal

अनुदेश

INSTRUCTIONS

- फार्म-1 का प्रेषण क.रा.बी. (साधारण) विनियम, 1950 के विनियम 11 व 12 के अंतर्गत विनियमित किया जाता है।
Submission of Form-I is governed by regulation 11 & 12 of ESI (General) Regulations, 1950
- "कुटुम्ब" से किसी बीमाकृत व्यक्ति के निम्नलिखित सभी अथवा कोई नातेदार अभिप्रेत है:-
अर्थात्:- (1) विवाहिता (2) बीमाकृत व्यक्ति पर आश्रित कोई धर्मज या दत्तक अवयस्क आश्रित बालक, (3) कोई बालक जो बीमाकृत व्यक्ति के उपार्जन पर पूर्णतः आश्रित है तथा जो (क) शिक्षा प्राप्त कर रहा है, उनके 21 वर्ष की आयु प्राप्त कर लेने तक (ख) कोई अविवाहित पुत्री, (4) कोई बालक जो किसी शारीरिक अथवा मानसिक अपसामान्यता या चोट के कारण शिथिलांग है तथा शिथिलांगता रहने तक बीमाकृत व्यक्ति के उपार्जन पर पूर्णतः आश्रित है, (5) आश्रित माता-पिता, (व्योरे हेतु क.रा.बी. अधिनियम, 1948 की धारा 2 के खंड 11 को देखें)।
"Family" means all or any of the following relatives of an Insured Person namely:-
(i) a spouse (ii) a minor legitimate or adopted child dependant upon the I.P.; (iii) a child who is wholly dependant on the earnings of the I.P. 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 dependant on the earnings of the I.P. so long as the infirmity continues; (v) dependant parents (Please see Section 2 clause 11 of the ESI Act 1948 for details).
- पहचान-पत्र अहस्तान्तरणीय है।
Identity Card is Non-Transferable.
- पहचान-पत्र के गुम होने की स्थिति में नियोजक/शाखा प्रबंधक को तत्काल सूचित किया जाए।
Loss of Identity Card be reported to Employer/Branch Manager immediately.
- किसी प्रकार की गलत सूचना देने की स्थिति में क.रा.बी. अधिनियम, 1948 की धारा-84 के तहत कानूनी कार्यवाही की जा सकती है।
Submission of false information attracts penal action Under Section 84 of ESI Act. 1948.
- नई नियुक्ति की स्थिति में भली-भांति भरा हुआ यह फार्म नियुक्ति के दस दिन के भीतर संबंधित शाखा कार्यालय में अवश्य ही प्रस्तुत किया जाना चाहिए। विलम्ब की स्थिति में नियोजक के विरुद्ध धारा-85 के तहत कानूनी कार्यवाही की जा सकती है।
This form duly filled in must reach the concerned Branch Office within 10 days of appointment of an Employee. Delay attracts penal action under Section 85 of the Act, against employer.
- बीमाकृत व्यक्ति होने के नाते आप व आपके परिवार के आश्रितजन चिकित्सा हितलाभ प्राप्त कर सकेंगे। अन्य नकद हितलाभ हैं, (1) बीमारी हितलाभ (2) अस्थायी अपंगता हितलाभ (3) स्थायी अपंगता हितलाभ (4) आश्रितजन हितलाभ (5) प्रसूति हितलाभ (महिला कर्मचारी के लिए)।
As an insured person you and your dependant family membes are entitled to full medical care. The other benefits in cash include (1) Sickness Benefit (2) Temporary Disablement benefit (3) Permanent disablement Benefit (4) Dependants benefit and (5) Maternity Benefit (in case of woman employees) subject of fulfillment of contributory cnditions.
- अधिक जानकारी के लिये कृपया निगम के वेबसाइट को देखें या शाखा कार्यालय या क्षेत्रीय कार्यालय से संपर्क करें।
For more details please contact website of ESIC at www.esic.org.in or contact Regional Office or Branch Office.

केवल शाखा कार्यालय में प्रयोग हेतु

For Branch Office Use only

- बीमा संख्या आवंटन की तारीख :
Date of allotment of Ins. No. : _____
- अस्थायी पहचान पत्र जारी करने की तारीख :
Date of Issue of T.I.C. : _____
- औषधालय का नाम/संख्या :
Name /No. of Dispensary : _____
- क्या अन्योन्य चिकित्सा व्यवस्था उपलब्ध है? यदि हां, तो उल्लेख करें :
Whether reciprocal Medical arrangements involved. if yes, please indicate : _____

शाखा प्रबंधक के हस्ताक्षर
Signature of Branch Manager

क्र.सं. Sl. No.	नाम Name	फार्म भरने की तारीख को आयु/जन्म-तारीख Date of Birth/Age as on date of filling form	कर्मचारी के साथ नातेदारी Relationship with the Employee	क्या उनके साथ रह रहे हैं? बताएं Whether residing with him/her.	यदि नहीं, तो आवास का स्थान दर्शाएं If No, state Place of Residence
				हाँ/Yes	नहीं/No
					कस्बा/Town
					राज्य/State