**IN QUADRUPLICATE** **FORM - 6**

Name of the Local Office

Employer's Code No. 00000000000000000

# Employee's State Insurance Corporation

(Return of Contribution) Regulation 26

Name & Address of the Factory of Establishment:
BOTTOMHALF PRIVATE LIMITED.
1-2-302, 1st Floor,M.G Road, Hyderabad -500033

PARTICULARS OF THE PRINCIPAL EMPLOYERS :-

a) Name: b) Designation:

c) Residential Address:

Period From 01 Apr 2025 To 30 Sep 2025

I furnish below the details of the Employer's and Employee's share of contribution in respect of the undermentioned insured person. I hereby declare that the return includes every employee directly or through an immediate employer or in connection with the work of the factory/establishment or any work connected with the administration of the Factory/establishment or purchase or raw materials, sale or distribution of finished products et.., to whom the contribution period to which this return relates, applies and that the contributins in respect of employer's and employee's share have been correctly paid in accordance with the provisions of the Act and Regulations relating to the payment of contributions vide challans detailed below :-

Total contribution amounting of **Rs.** comprising of **Rs.** as Employer's share and **Rs.** as Employee's share (Total of Col. 6 of the Return) paid as under :

Place : ..... Signature: .....
Date : ..... Designation: .....

**Important Instructions :**

1. Infromation to be given in "Remarks Column *No. 8)"
   (i) If any I.P. is appointed for the first time and/or leaves service during the contribution period, indicate "A..... (Date)" and /or "L ..... (date)", in the remarks coluinn (No. 8.)
   (ii) Plese indicate the naem of the dispensary to which the insured person is attached (To be furnished only once)
   (iii) Please indicate the name of the dispensary to which the insured person is attached in case of new entrants
   (iv) In case there is change in the name of the dispensary, plese indicate the name of the new dispensary in the remarks columns
2. Please indicate Insurance Numbers in chronological (ascending) order.
3. Figures in colunns 4,5 & 6 of the Return
4. Invariably strike totals of columns 4,5 & 6 fo the Return
5. No over-writing shall be made. Any corrections should be signed by the employer.
6. Every page of this return should bear full signature & rubber stamp of the employer.
7. "Daily Wages" in Col. 7 of the return shall be calculated by dividing figures in Col. 5 by figures in Col. 4 to two decimal places.

| Sl. No | Insurance No. | Name of the Insured Person | No of days for which wages paid | Total amount of wages paid | Employee's Contribution Deducted | Average Daily/ Wages | Whether still continues working and drawing wages within the insurance wages celing | Name of the Dispensary of the I.p. | Remarks |
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