EMPLOYEES’ STATE INSURANCE CORPORATION

REG. FORM – 18

CERTIFICATE OF EXPECTED CONFINEMENT/CONFINEMENT/MISCARIAGE MATERNITY BENEFIT

(REGULATION 88 & 89)

Signature or thumb impression of the Insured Woman

Employer’s Code No. . . . .

Book No. . . . .

Serial No. . . . .

Insured Woman’s Name . . . .

Insurance No. . . . .

Wife/Daughter of . . . .

Stamp of the Dispensary

I.* Certified that I have examined the above mentioned Insured Woman today and that in may opinion she may expect to be confined on or about. . . . .

II.* Certified that I attended the above mentioned Insured woman in connection with her confinement/miscarriage at . . . . (address) and that she was there delivered of a child on the . . . . day of . . . .

Signature of midwife, if any

Date: . . . .

Any Remarks . . . .
. . . .

Signature or counter signature of the Insurance Medical Officer

Name in Block letters and Rubber stamp

* Delete whichever is not applicable.