

FILE NO :

EMP NO :

ANNUITY NO :



UNITED INDIA INSURANCE CO. (EMPLOYEES') PENSION FUND
24, Whites Road, Chennai - 600 014

APPLICATION FOR PAYMENT OF PENSION

I hereby apply for payment of pension to which I am entitled under General Insurance (Employees') Pension scheme 1995. Necessary particulars related to my appointment are given in the statement below.

1. Name in Full : PAN No. : (Enclose PAN copy - Mandatory)

2. Emp No. : 3. Designation :

4. Office Last Worked :

Table with 4 columns: Dt. of Birth, Dt. of Joining, Dt. of Exit, MODE OF EXIT. Includes a 'Place for Photo' box on the right.

In case of FTS, Date of joining as PTS _____ Date of joining as FTS _____

No of working hours as PTS : _____ PTS Service : Years Months Days

6. Residential Address :

Phone No. Mobile No. Pincode :

7. Name of the Bank :

Address of the Bank :

Account No. MICR/IFSC Code No.

Pass Book Xerox Copy enclosed : (Enclose cancelled cheque leaf)

Bank Phone No.

8. (A) Last Promotion if Any (during last TEN Months)

(1) Date of Promotion :

(2) Basic before Promotion :

(3) Fixation of Basic in New cadre :

(4) New Basic w.e.f. :

(B) Last Promotion if Any :

Date of Promotion :

I hereby declare that the particulars given above are true to the best of my knowledge.

Place :

Signature of the Employee

Date :

Name in Full :

DETAILS OF THE MEMBERS OF THE FAMILY (COMPULSORY)

Name of the Employee :

Designation :

Office Last Worked :

Date of Birth :

Date of Appointment :

Date of Exit :

Details of the members of the family as on :

I hereby give the details of the members of my family as required for the purpose of payment of Family Pension in accordance with the provisions of General Insurance (Employees') Pension Scheme.1995:
(Please mention if physically/mentally handicapped in remarks column)

Sl No.	Name	Date of Birth	Relationship to the Employee	Remarks, If any
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

I hereby undertake to keep the above details upto date, notifying the office any addition or alteration, if any.

Place :

Signature of the Employee

Date :

Form of Nomination for the receipt of Commuted Value in the event of death of the Pensioner without receiving the Commuted Value

Ihereby nominate the person named below to receive the Commuted Value of Pension in the event of my death before receiving the commuted Value of Pension.

1. Name and address of Nominee :
2. Relationship with the Pensioner :
3. Date of Birth of the Nominee : Age
4. If nominee is minor, name and address of person who may receive the Commuted Value of Pension during the nominee's minority :
5. Name and address of other nominee in case of nominee Under (1) above predeceases the pensioner :
6. Relationship with the Pensioner :
7. Date of Birth : Age
8. If the other nominee is minor, name and address of person who may receive the Commuted Value of Pension during the other nominee's minority. :

Place :

Signature of the Employee

Date :

Name in Full :

WITNESS

Witness Name & Address

Form of application for commutation of a fraction of Pension without Medical Examination

Re : Commutation of Pension without Medical Examination

I retired from the services of the Company with effect from _____ and opted to be governed by the General Insurance (Employees') Pension Scheme, 1995. I desire to commute a fraction of my pension in accordance with the said Pension Scheme.

The necessary particulars are given below :-

Name in Full :
 Emp No. :
 Designation at the time of Retirement :
 Office last worked :
 Date of Birth :
 Date of Exit :
 Mode of Exit :

(not exceeding 1/3rd of Pension)

TO BE INDICATED WITHOUT FAIL : Other Perc :

 Signature of the Employee

Date : _____ (Name in Full)

UNITED INDIA INSURANCE CO. (EMPLOYEES') PENSION FUND

RECEIPT

ANNEXURE - 9

Received from United India Insurance Co. (Employees') Pension Fund, Chennai - 600014, the sum of RS..... (Rupees.....) being the commuted value of pension payable in accordance with the provisions of General Insurance (Employees') Pension scheme, 1995.

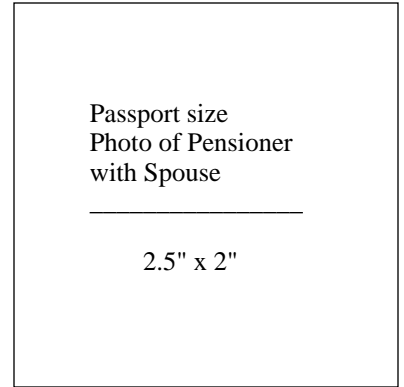
Affix
 Revenue
 Stamp###

Place : _____
 Date : _____
 Signature of the Employee

Name in Full :
 Emp No. :
 Designation at the time of Retirement :
 Office last worked :

SPECIMEN SIGNATURE - CUM PHOTO IDENTITY CARD

Name :
Emp No. :
Residential :
Address



PINCODE

Designation at the time of retirement :

Office last worked :

Signature of Employee :

Signature of Spouse :

SIGNATURE OF ATTESTATION OFFICER*

Office Seal

Signature

Name in Full

Emp No.

Date

Designation

**VERIFICATION **
(FOR H.O. I R.O. USE ONLY)**

This is to certify that the above particulars as declared by the retired employee concerned have been verified and found to be correct as per office records which I have seen Personally.

Office Seal :

Signature

Name in Full

Emp No.

Date

Designation

NOTE:

Any addition! alteration in the text of the form will make the option invalid.

ATTESTATION:

This form is to be countersigned and signature of the applicant (retired employee) attested by a Class I Officer of the Company.

VERIFICATION: ,

The particulars furnished by the retired employee have to be certified as having been verified and found to be correct by the designated officer of the Personnel Department at RO/HO, not below the rank of Deputy Manager.

EMPLOYEE'S BIO DATA CALCULATION SHEET

FOR CALCULATION OF PENSION

(To be filled by the Office Last worked without leaving any column blank)

- 1. Name of the Employee : _____
- 2. Emp No. : _____
- 3. (a) Designation at the time of retirement : _____
- (b) Office last worked : _____
- 4. (a) Name of the Erst while unit : _____
- (b) Is he eligible for pension or any Superannuation, benefits from Erstwhile unit, if so, give full details : _____

5. Date of

	BIRTH	JOINING	RETIREMENT	VRS	MEDICAL GROUNDS

- (a) VRS Notice Date : _____
- (b) Date of Acceptance : _____
- (c) No of Days Waived : _____

6. Total service as on the date of Retirement,.....Years.....Months.....Days

- 7.

(a) Extraordinary leave on Loss of pay granted on Medical Certificate.	Total No. of Days
(b) Extraordinary leave on Loss of pay availed on grounds other than Medical (furnish full Particulars).	Total No. of Days
(c) Break in Service, If any, due to suspension (give full particulars)	Total No. of Days
- 8.

Periods not to be counted as Qualifying service i.e., EOL other than Medical Certificate , Dies-Non , etc.,	Total No. of Days
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- 9. Disciplinary proceedings pending if any with details : _____
- 10. (a) Any Company Owned/ Leased Accommodation Allotted : _____
- (b) If Yes, Details : _____
- (c) Whether the same has been vacated and date of vacation : _____

10. PAY FOR THE LAST 10 MONTHS INCLUDING THE MONTH IN WHICH EMPLOYEE RETIRED

IF ANY EMPLOYEE ON LOSS OF PAY, PAST 300 WORKING DAYS SALARY TO BE MENTIONED PLEASE ENCLOSE SALARY LEDGER FOR 10 MONTHS

Sl. No.	Month	Year	EXISTING	
			Basic	Fixed per Allowance basic portion
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

11. "Pay" drawn at the time of Retirement (indicate separately) :
- (a) Basic pay :
- (b) Increment compound of fixed Personal allowance :
- (c) Other allowance which count for P.F. :
- (d) Normal Increment month :
- (e) Stagnation Increment month Year

(Signature of the Authorised Official)

Name :

Emp. No. :

Designation :

Office Address :

.....

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Prepared by

Checked by



**VERIFICATION
(FOR H.O. / R.O. USE ONLY)**

This is to certify that the above particulars in respect of the employee concerned have been verified and found to be correct as per office records which I have seen Personally.

(Signature of the Verifying Official)

Name:

Emp No:

Designation :

Office Address:

Date:

Office Seal:

VERIFICATION:

The particulars furnished by the retired employee have to be certified as having been verified and found to be correct by the designated officer of the Personnel Department at RO/HO, not below the rank of Deputy Manager.