Employees' Old-Age Benefits Institution

CLAIM FORM

کلیم فارم

PE-03

(For Invalidity Pension)

برائے معذوری پنشن

Under Regulation (3) of EOB (Payment of Invalidity Pension) Regulation, 1983

زیر دفعہ (3) ای او بی (ادائیگی برائے معذوری پنشن) ریگولیشن مجریہ 1983ء

PART A

The following documents should be supplied with this form: **EOBI Registration Card** **Attested Photocopy of CNIC (both Sides)** **Two recent passport size photographs duly attested**	اس فارم کے ساتھ مندرجہ ذیل دستاویزات منسلک کریں ای او بی آئی رجسٹریشن کارڈ قومی شناختی کارڈ کی تصدیق شدہ نقل (دونوں رخ) دو حالیہ پاسپورٹ سائز تصویریں (تصدیق شدہ)

PART B

Name of the Claimant: دعویدار کا نام _____

Age/Date of Birth: عمر/تاریخ پیدائش _____

CNIC No. : قومی شناختی کارڈ نمبر _____

Registration Number : رجسٹریشن نمبر _____

Address: پتہ _____

POSITION OF INSURABLE EMPLOYMENT TO DATE:

S. No نمبر شمار	Name and Address of Employer	Employer Registration No. آجر کا رجسٹریشن نمبر	Period of Insurable Employment بیمہ شدہ ملازمت کی مدت

Continue on separate sheet if necessary اگر ضروری ہو تو علیحدہ کاغذ منسلک کریں

Total Period of Insurable Employment بیمہ شدہ ملازمت کی کل مدت: _____

Date of sustaining invalidity: معذوری لاحق ہو جانے کی تاریخ _____

How and where invalidity sustained: معذوری کب اور کس طرح لاحق ہوئی _____

Monthly wages (a) immediately before sustaining invalidity:

معذوری لاحق ہونے سے فورا قبل کی ماہانہ اجرت _____

(b)After sustaining invalidity if any:

معذوری لاحق ہونے کے بعد کی ماہانہ اجرت اگر ہو تو _____

If unemployed at present, since when? اگر آپ بیروزگار ہیں تو کب سے؟ _____

I _____ **s/o, w/o, d/o** _____

do hereby solemnly declare and verify that the information given above is true and current, to the best of my knowledge and no material facts have been concealed. I claim Invalidity Pension.

Date _____ **Place** _____ **Signature** _____

اس جگہ دو دستخط یا انگوٹھے کے نشان لگائیں

CERTIFICATE OF LAST EMPLOYER

آخری آجر کا سرٹیفیکیٹ

It is certified that Mr./Mrs./Miss _____ s/o, d/o, w/o _____ is/was an insured person at this establishment and that the details furnished by him/her in this form are correct to the best of our knowledge and information.

It is further certified that the invalidity was not sustained by him/her as a result of occupational disease or an accident out of or in the course of his/her employment.

It is further certified that:

(a) He/she is not employed with us after sustaining the invalidity.

(b) He/she continues to be employed with us after sustaining the invalidity and is being paid Rs. _____ as wages instead of Rs. _____ which was being paid to him/her immediately before sustaining invalidity.

(c) All monthly contributions in respect of him/her are duly paid to E.O.B.I.

(d) His current contribution card is enclosed/already supplied to E.O.B.I.

(e) Our record of monthly wages paid to him/her over the last 36 calendar months of service shows. (Attach statement of the last 36 months wages)

Seal of the Establishment

ادارے کی مہر

Signature: _____

Name:_____

Designation: _____

(The institution reserves the right to inspect the record of the employer and recover any unpaid contributions with late fee calculated in prescribed manner.)

MEDICAL CERTIFICATE TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Certified that Mr./Mrs./Miss. _____ s/o, d/o, w/o _____ whose particulars are given in this form is was under my treatment since _____ he/she is/was suffering _____ percent/permanent incapacity for work. In my opinion, his/her invalidity may continue for a period of at least _____ months _____ days from the date of sustaining invalidity.

Official Seal

Date: _____

Address: _____

Signature: _____

Name: _____

FOR OFFICE USE ONLY

صرف دفتری استعمال کے لئے

Date of receipt of Claim Form: _____

Receiving Office: _____

Name and signature of the receiving officer: _____

Claim of Old Age Pension/Enhanced Old Age Pension/Old Age Grant/Widow Pension amounting to Rs._____ p.m/lump sum w.e.f. _____

Approved _____ .

Claim rejected for the following reasons:

_____	_____	_____
Prepared by	**Checked by**	**Approved by**

Claim Form No. _____

Mr. / Miss/ Mrs. _____

s/o, w/o, d/o: _____

Received on: _____

Seal/Signature: _____

TO THE REGIONAL HEAD,

EOBI Region _____

With utmost respect, it is hereby stated that my details are as under:

Name: _____ Father/Husband name: _____

Spouse Name: _____ CNIC Number: _____

Current Address: _____

Permanent Address: _____

EOBI Registration No: _____ Employer Name: _____

Date of Birth: _____ Mobile Number: _____

Date of Registration: _____ Date of Retirement: _____

I hereby declare to the best of my knowledge that the above details are true and correct to the best of my knowledge and no material facts have been concealed. Therefore, kindly issue me a Claim form.

Dated: _____ Signature: _____

CERTIFICATE OF LAST EMPLOYER

It is certified that Mr./Mrs./Miss _____ s/o, d/o, w/o _____ is/was an insured person at this establishment and that he/she is/was in the service of this establishment from _____ to _____ . His date of birth according to our record is _____

Employer Registration No. : _____ Seal/Signature of Employer:_____

FOR OFFICE USE ONLY

Date of applicability of EOBI Act on the establishment: _____ Age at the time of applicability: _____ Date of Application: _____

Total Insurable Period: _____

Claim Form no. _____ is hereby issued dated _____ .

_____

Benefits Incharge

UNDERTAKING FROM INSURED PERSONS / CLAIMANTS

I _____ s/o, w/o, d/o _____ EOBI Number _____ CNIC Number _____ hereby undertake that I/My husband/my wife has not served in any other establishment except mentioned in the claim form PE-03/PE-04/PE-05 and I would not challenge decision of the region on question of insurable employment except for insurable employment in the claim form mentioned above. It is further clarified that neither I nor my husband/my wife has applied for any benefits or received any benefits from EOBI.

_____ _____

Claimants' Name Thumb Impression/Signature

EMPLOYER DECLARATION / CERTIFICATE

It is certified that Old Age/invalidity/Grant/Widow's pension in respect of

Mr. /Ms. _____ s/o, w/o, d/o _____ has not been submitted previously to EOBI. In case EOBI suffer any loss on account of incorrect information by us, we undertake to make good the loss of repaying the amount of claimant/EOBI.

_____ _____

OFFICIAL SEAL EMPLOYER SIGNATURE

SERVICE CUM AGE CERTIFICATE

This is to certify that Mr./Ms. _____ s/o,w/o,d/o _____ has served from _____ to _____ in this organization and his date of birth as per our record is _____.

_____ _____

OFFICIAL SEAL EMPLOYER SIGNATURE

SALARY STATEMENT

The salary/wages statement in respect of Mr./Ms. _____ s/o, w/o, d/o _____ for the period _____ to _____ is given below.

MONTH/YEAR	WAGES	MONTH/YEAR	WAGES
January /		January /	
February /		February /	
March /		March /	
April /		April /	
May /		May /	
June /		June /	
July /		July /	
August /		August /	
September /		September /	
October /		October /	
November /		November /	
December /		December /	

_____ _____

OFFICIAL SEAL EMPLOYER SIGNATURE

EMPLOYEES' OLD AGE BENEFITS INSITUTION

PENSIONER'S DETAILS

NAME: _____

FATHER NAME : _____

OLD NIC NUMBER : _____

CNIC NUMBER : _____

PERMANENT ADDRESS: _____

_____

CURRENT ADDRESS: _____

_____

TEHSIL: _____

DISTRICT:_____

PHONE NUMBER: _____

_____ _____

THUMB IMPRESSION/SIGNATURE **DATE**

REQUIRED DOCUMENTS

1. EOBI Registration Card (Original)
2. CNIC of Claimant (Attested Photocopies X 2)
3. CNIC of Claimant's Spouse (Attested Photocopies X 2)
4. Pictures of Claimant (Attested Pictures X 4)
5. Pictures of Claimant's Spouse (Attested Pictures X 4)
6. Family Registration Certificate from NADRA (Attested Photocopy)
7. Service Certificate from Employer/s (Original)
8. Personal File of Service from Employer/s (Photocopy)
9. Medical Record from Attending Physician

EMPLOYEES OLD AGE BENEFITS INSTITUTION