

EMPLOYEES' TRUST FUND BOARD
Application for permanent Disability Insurance Cover

For office use only

Part I [To be completed by the member]

- 01. I. Name of member (with initials).....**
.....
- II Names denoted by initials**
.....
- 02. Address :.....**
.....
- 03. (i) Age:..... (ii) Date of Birth:.....**
- 04. National Identity Card No :.....**
- 05. Employer's name & Address:.....**
.....
- 06. I. EPF/PPF Number of Employer:.....**
II. Membership No:.....
- 07. Date of joining the establishment;.....**
- 08. Details of Bank Account : (i) Name of Bank**
(ii) Bank Branch
(iii) Account No
- 09. Date of Accident/Commencement of Illness:.....**

- 10. Nature of Accident /Illness :.....
- 11. Date of admission to Hospital ;.....
- 12. Date of discharged from Hospital;.....
- 13. Name of hospital to which you were admitted:.....
.....
- 14. Have you become permanently disabled as a result of the accident;
.....
If so the effective date of disability as recommended by the Medical Officer.
.....
- 15. Date of loss of employment due to permanent disability:.....

I do hereby declare that the foregoing facts are true and correct. I am aware that I shall be liable for prosecution in a Court of Law if I have furnished any false information.

Thumb impressions of member:

Left

Right

.....

Signature of Member

Date ;.....

Telephone No:.....

EMPLOYEES' TRUST FUND ACT NO. 46 of 1980
Medical Certificate

To: The Chairman, Employees' Trust Fund board, Colombo 5

I,being
a registered Medical Practitioner bearing Registration No.....do hereby declare
that I have this.....day of20.....examined

.....
[name of patient]

who is a member of the Employees' Trust Fund and I certify that the said.....
.....is suffering from.....
..... and in consequence permanently
and totally incapacitated and unfit for work any longer. The percentage of disability is
.....%.

The said.....placed
his/her signature and thumb marks on this certificate in my presence.

Thumb marks of member:

Left

Right

.....
Signature of Member

.....
Signature of Medical practitioner

Date ;.....

Seal :

Telephone No: