FORM 6

Employees' State Insurance Corporation

RETURN OF CONTRIBUTIONS

(In quadruplicate)

[Regulation 26]

Employer's Code No. ……

Name of Branch Office ……

Name and address of the factory or establishment……

Particulars of the principal employer

(a) Name : ……

(b) Designation :……

(c) Residential address :……

Period : From…… to ……

I furnish below the details of the employer's share of contributions in respect of the under mentioned insured persons. I hereby declare that the return includes every employee, employed directly or through an immediate employer or in connection with the work of the factory / establishment or purchase of raw materials, sale or distribution of finished products, etc. to whom the contribution period to which this return relates, applies and that the contributions 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 to Rs…… comprising of Rs…….. as employer's share and Rs. ……. as Employee's share (Total of col.6 of the return) paid as under:

(1) Challan dated……. for Rs…….

(2) Challan dated……. for Rs…….

(3) Challan dated……. for Rs…….

(4) Challan dated……. for Rs…….

(5) Challan dated……. for Rs…….

(6) Challan dated……. for Rs…….

Total : Rs…….

Place ……. Signature……

Date : Designation……

Important instructions

1. 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 column (No.8). (Please indicate the name of the dispensary to which the insured person is attached in the case of new entrants and if there is change in the name of the dispensary, indicate name of new dispensary in the remarks column.)
2. Please indicate insurance numbers in chronological ascending order.
3. Figures in columns 4,5 and 6 shall be in respect of wage periods ended during the contribution period.
4. Invariably strike totals of columns 4, 5 and 6 of the return.
5. No overwriting shall be made. Any corrections should be signed by the employer.
6. Every page of this return should have full signature and rubber stamp of the employer.
7. 'Daily wages' in column 7 of the return shall be calculated by dividing figures in column 5 by figures in column 4, to two decimal places.

Sl. No.	Insurance No.	Name of Insured Person	No. of days for which wages paid	Total amount of wages paid Rs. Ps.	Employees' contribution deducted Rs. Ps.	Average daily wages (5 / 4) Rs. Ps.	Whether still continuous working and drawing wages within the insurable wage ceiling	Remarks
1	2	3	4	5	6	7	7A	8

Entitlement position marked total of 5 of return checked and found correct/ correct amount is indicatead

Checked the amount of employer's and employees' contribution paid which is in order/ observation memo enclosed.

COUNTERSIGNED

Signature ………………………………

Designation ……………………………

UDC **HEAD CLERK** **HEAD CLERK** **BRANCH OFFICER**

FORM 6
Continuation sheet

Employees' State Insurance Corporation

Sl. No.	Insurance No.	Name of Insured Person	No. of days for which wages paid	Total amount of wages paid Rs. Ps.	Employees' contribution deducted Rs. Ps.	Average daily wages (5 / 4) Rs. Ps.	Whether still continuous working and drawing wages within the insurable wage ceiling	Remarks
1	2	3	4	5	6	7	7A	8

Signature ……………………..