



EMPLOYEES’ STATE INSURANCE CORPORATION

REG. FORM – 21

DEATH CERTIFICATE IN CASE OF CONFINEMENT FOR CLAIMING MATERNITY BENEFIT

(Under Regulation 89A)

Stamp of the Dispensary

Book No. . . . . Name of the deceased  
Insured woman . . . . .  
Serial No. . . . . W/D of . . . . .  
Insurance No. . . . .

I certify that in my opinion –

- i) the above-named deceased Insured Woman died on . . . . . as a result of . . . . . during her confinement/\* during a period of . . . . . weeks (cause of death) immediately following her confinement, leaving behind the child.
- \*ii) the said child also died on . . . . . as a result of . . . . .

Also certified that I had been attending her\*/ and also her said child for providing medical benefit before \*her death/ her said child’s death and I attended her for the last time on . . . . . and her said child for the last time on . . . . .

Any other remarks  
. . . . .  
. . . . .

Date . . . . . Signature of Insurance Medical Officer/  
Insurance Medical Practitioner

Rubber Stamp and name  
in Block letters

- NOTE: (1)\* Please delete whichever is not applicable.
- (2) The language may be suitably amended if the Insurance Medical Officer/ Insurance Medical Practitioner had not attended the deceased person before her/ her child's death.