# EMPLOYEES' STATE INSURANCE CORPORATION

**REG. FORM – 17**

**CERTIFICATE/NOTICE OF PREGNANCY**
**MATERNITY BENEFIT**
**(REGULATION 87)**

**Signature or thumb impression of the Insured Woman**

Employer's Code No. . . . . Book No. . . . . .

Serial No. . . . . .

Insured Woman's Name . . . . . .

Insurance No. . . . . .

Wife/Daughter of . . . . . .

**Stamp of the Dispensary**

Certified that I have examined the above mentioned Insured Woman today and that in my opinion she is pregnant and her pregnancy appears to be. . . . . .weeks old.

**Signature of midwife, if any**

Dated: . . . . . .

**Signature or counter signature of the Insurance Medical Officer**

**Name in Block letters and Rubber stamp**

Any other Remarks. . . . . .

. . . . . .. . . . . .

I, . . . . . Insurance No. . . . . Wife/daughter of. . . . . .

. . . . . hereby give notice of pregnancy.

Present address. . . . . .

. . . . . .

Present/last employer. . . . . .

Date. . . . . .

**Signature or thumb impression of the Insured Woman**