**EMPLOYEES’ STATE INSURANCE CORPORATION**

# FORM-1

To be filled in by the employee after reading instructions overleaf. Two Postcard Size photographs are to be attached with this form. This form is free of cost.

(A) INSURED PERSON’S PARTICULARS (b) EMPLOYER’S PARTICULARS

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Insurance No. |  | | | | | |
| 2 Name (in block  letters) | ABHISHEK PATEL | | | | | |
| Father’s/  Name | KAILASH PATEL | | | | | |
| Date of Birth | D  08 | M  12 | | Y  1992 | Marital Status | M/U/W  U |
|  |  |  | |  | 6.Sex | M |
| 7. Present Address | | | 8. Permanent Address | | | |
| H-wing, Room no-1007,  Mahalaxmi SRA CHA, P.B  Marg, near Mahindra tower worli - mumbai | | | H-wing, Room no-1007,  Mahalaxmi SRA CHA, P.B  Marg, near Mahindra tower worli - mumbai | | | |
| Pin Code 400030……………… | | | Pin Code 400030………… | | | |
| e-mail address  abhishekpatel1238@gmail.com | | | e-mail address  abhishekpatel1238@gmail.com | | | |
| Branch Office | | | Dispensary | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employer’s Code No. |  | | | |
| 10. Date of Appointment | Day | | Month | Year |
|  | |  |  |
| 11. Name & Address of the Employer | | | | |
| 12. In case of any previous employment please fill up the details as under:- | | | | |
| a) Previous Ins.No. | |  | | |
| b) Emplr’s Code No. | |  | | |
| C) Name & address of the Employer  e-mail address | | | | |

# Details of Nominee u/s 71 of ESI Act 1948/Rule 56(2) of ESI (Central) Rules, 1950 for payment of cash benefit in the event of death.

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Address |
| AMIT KAILASH PATEL | BROTHER | H-wing. Room no – 1007, Mahalaxmi SRA CHS, P.B Marg, near Mahindra tower, worli, Mumbai - 400030 |

I hereby declare that the particulars given by me are correct to the best of my knowledge and belief. I undertake to intimate the Corporation any changes in the membership of my family within 15 days of such change.

Counter signature by the employer

Signature with Seal

1. FAMILY PARTICULARS OF INSURED PERSON

Signature/T.I.of IP

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sl.  No. | Name | Date of Birth/ Age as on date of  filling form | Relationship with the Employee | Whether residing with  him/her? | | If’No’, state place of Residence | |
|  |  |  |  | Yes | No | Town | State |
| 1. | KAILASH PATEL | 27 | FATHER | YES |  |  |  |
| 2. | AMRAVATI PATEL | 48 | MOTHER | YES |  |  |  |
| 3. | AMIT PATEL | 54 | BROTHER | YES |  |  |  |
| 4. |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |
| 6. |  |  |  |  |  |  |  |

………………..………………………………………………………………………………………………………………………………………………………………

ESI Corporation (Valid for 3 months from the date of appointment) Temporary Identity Card

|  |  |  |
| --- | --- | --- |
| Name |  | |
| Ins.No. |  | Date of appointment |
| Branch Office |  | Dispensary |
| Employer’s Code No. & Address |  | |

Space for photograph

Validity:

Dated: Signature/T.I. of I.P Signature of B.M. with Seal

* 1. Submission of Form-1 is governed by regulations 11 & 12 of ESI (General) Regulations, 1950.
  2. “Family” means all or any of the following relatives of an Insured Person namely:-

(i) A spouse (ii) a minor legitimate or adopted child dependant upon the I.P;(iii) a child who is wholly dependant on the earnings of the I.P. and who is (a)receiving education, till he or she attains the age of

21 years (b)an un married daughter; (iv) a child who is infirm by reason of any physical or mental abnormity or injury and is wholly dependant on the earnings of the I.P. so long as the infirmity continues; (v) dependant parents (Please see Section 2 clause 11 of the ESI Act 1948 for details).

* 1. Identity Card is Non-transferable.
  2. Loss of Identity Card be reported to Employer/Branch Manager immediately.
  3. Submission of false information attracts penal action under Section 84 of ESI Act, 1948.
  4. This form duly filled in must reach the concerned Branch office within 10 days of appointment of an Employee. Delay attracts penal action under Section 85 of the Act, against employer.
  5. As an Insured person you and your dependent family members are entitled to full medical care. The other benefits in cash include (1) sickness Benefit (2) Temporary Disablement benefit (3) Permanent disablement Benefit (4) Dependents benefit and (5) Maternity Benefit (incase of women employees

subject to fulfillment of contributory conditions.

* 1. For more details Please Visit website of ESIC at [WWW.esic.nic.in](http://WWW.esic.nic.in/) or [www.esickar.gov.in](http://www.esickar.gov.in/) contact Regional office or Branch Office.

# FOR BRANCH OFFICE USE ONLY

1. Date of Allotment of Ins. No.
2. Date of issue of TIC :
3. Name/ No. of Disp :
4. Whether reciprocal Medical arrangements involved? If yes, please indicate :

Signature of Branch Manager

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sl.  No. | Name | Date of Birth/Age as on date of filling form | Relationship with the Employees | Whether residing with him/her? | | If ‘No’, state place of Residence | |
|  |  |  |  | Yes | No | Town | State |
| 1 | KAILASH PATEL | 27 | FATHER | YES |  |  |  |
| 2 | AMRAVATI PATEL | 48 | MOTHER | YES |  |  |  |
| 3 | AMIT PATEL | 54 | BROTHER | YES |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |