



DECLARATION FORM

Form-1

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

(A) INSURED PERSON'S PARTICULARS

1. Insurance No.			
2. Name in block letters			
3. Father's/Husband's Name			
4. Date of Birth	Day	Month	Year
5. Marital Status	Married	Unmarried	Widow
6. Sex	Male Female		
7. Present Address	8. Permanent Address		
Pin Code	Pin Code		
Branch Office	Dispensary		

(B) EMPLOYER'S PARTICULARS

9. 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) Employer's Code No.			
(c) Name & Address of the Employer			
Phone number / e-mail address			

(C) 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

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 /T.I.of IP.

Signature with seal

(D) Family Particulars of Insured person

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							
2							
3							
4							
5							
6							
7							

ESI Corporation Temporary Identity Card

(Valid for 3 month from the date of appointment)

Name	
Insurance Number	
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

INSTRUCTIONS

- 1 Submission of Form-I is governed by regulation 11 & 12 of ESI (General) Regulations, 1950
- 2 Family means all or any of the following relatives of an Insured Person namely:-
(i) spouse (ii) a minor legitimate or adopted child dependent upon the I.P.; (iii) a child who is wholly dependent 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 unmarried daughter; (iv) a child who is infirm by reason of any physical or mental abnormality or injury and is wholly dependent on the earnings of the I.P. so long as the infirmity continues; (v) dependent parents (Please see Section 2 clause 11 of the ESI Act 1948 for details.
- 3 Identity Card is Non-Transferable.
- 4 Loss of Identity Card be reported to Employer/Branch Manager immediately.
- 5 Submission of false information attracts penal action Under Section 84 of ESI Act. 1948.
- 6 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.
- 7 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 (in case of woman employees) subject of fulfillment of contributory conditions.
- 8 For more details please contact website of ESIC at www.esic.org.in or contact Regional Office or Branch Office.

For Branch Office Use only

1. Date of allotment of Ins. No. : _____
2. Date of Issue of T.I.C. : _____
3. Name /No. of Dispensary : _____
4. Whether reciprocal Medical arrangements involved. if yes, please indicate :

Signature of Branch Manager

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							
2							
3							
4							
5							
6							
7							