FORM-1

DECLARATION FORM

Emp id :

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

1 Insurance No.

2 Name (in block letters)

3 Father/ Husband's Name

4 Date of Birth

D	M	Y

5 Marital Status M/U/W

6 Sex M / F

7 Present Address

Pin Code

E-mail address

Branch office :

8 Permanent Address

Pin Code

E-mail address

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 pervious 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

(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

(D) FAMILY PARTICULARS OF INSURED PERSON

Sl.No	Name	Date of Birth / Ages as on date of filling form	Relationship with the Employee	Whether residing with him/her? Yes	No	If No. state place of Residence /Town	/State

ESI Corporation Temporary Identity Card

(Valid for 3 months from the date of appointment)

Name **Employee id**	
Ins No.	
Dispensary	
Date of Appointment	
Branch office	
Employer's Code No. & Address	

(Space for Photograph)

Validity :

❖

Dated :

Signature / T.I. of I.P

Signature of B.M. with seal

I declare that my dependent parents Income from all sources is 1) Father's Income Rs. _____ (2) Mother's Income Rs._____ Total Rs. _____ (Rupees _____) and he/she/they, is /are wholly dependent on me and also resides with me.

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 with 15 days of such change

for

Authorised Signatory

Counter signature by the employer
Signature with seal

Dated :

❖

Signature / T.I. of IP

INSTRUCTIONS

1 Submissions 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 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 women employees) subject to fulfillment of contributory conditions.
8 For more details please visit 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 TIC : _____

3 Name / No. of Disp.: _____

4 Whether reciprocal Medical arrangements involved? If yes, please indicate _____

Signature of Branch Manager

Sl.No	Name	Date of Birth / Ages 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						