Employer's Code No.

**DECLARATION FORM FORM - 1**

**(A) Insured Person's Particulars (B) Employer's Particulars**

|  |  |  |  |
| --- | --- | --- | --- |
| **1 Insurance No.** |  | | |
| **2 Name**  **(in block capital)** | [Candidate Name] | | |
| **3 Father's/**  **Husband's Name** | [FatherName] | | |
| **4 Date of Birth** | **DD MM YY** | **5. Martial Status** | **[Married]** |
| **6. Sex** | **[Gender]** |
| **7 Present Address**  **[Address]**  **e-mail [Email] Number [Mobile]** | | **8. Permanent Address**  **[Address]**    **e-mail [Email]**  **Number [Mobile]** | |
| **Branch office:** | | **Dispensary :** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **10. Date of Appointment** |  |  |  |
|  | | |
| **11. Name & Address of the employer**  **Department Name** | | | |
| **12. In case of any previous employment please fillup the details as under:-** | | | |
| **Previous Ins. No.** |  | | |
| **Emplrs. Code No.** |  | | |
| **11. Name & Address of the employer** | | | |
|  | | | |

[Date of Birth]

|  |  |  |
| --- | --- | --- |
| Day | Month | Year |

[Date of Joining]

(c) Details of the nominee u/s 71 of ESI Act1948 / Rule 56(2) of ESI (Central) Rules 1950 for payment of cash benefit in the event of death

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Nominee** |  | **Relationship with insured person** | **Address** |
|  |  |  |  |

**I hereby declare that the above particulars have been given by me and are correct to the best of my knowledge and I belief. I also under take to intimate to the corporation any change in the membership of my family within 15 days of such change having occured.**

**Counter Signature of the Employer**

**Signature with Seal Signature / T.I. of I P**

1. **FAMILY PARTICULARS OF INSURED PERSON**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sl.**  **No.** | **Name** | **Date of Birth** | **Relationship with**  **insured person** | **Whether residing with**  **him/her or not** | **If No, State place of**  **Residence** | |
|  |  |  |  | **YES / NO** | **TOWN** | **STATE** |
| **1** |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Account Number** | **IFSC Code** | **Branch Name** |
| [Account No] | [IFSC] |  |

**ESI CORPORATION**

**Temporary Identity Card Valid for 3 months from the date of appointment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | [Candidate Name] | | |
| **Ins. No** |  | **Date of Entry** | [Date of Joining] |
| **Father's/**  **Husband's Name** | [FatherName] | **Date of Birth** | [Date of Birth] |
| **Branch Office** |  | **Dispensary** |  |
| **Name, Address & Code No. of the employer** |  | | |

**(Space for photograph)**

**Validity**

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

# INSTRUCTIONS

* 1. **Submission of Form 1 is governed by regulations 11 & 12 of ESI (General) Regulations, 1950**
  2. **\*Family\* means all or any one of the following relatives of an insured person namely:-**
     1. **a 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 un married 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 infirmly continues; (v) dependent Parents**
  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 dully 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 the employer**
  7. **As an insured person you and your dependent family members are entitled to full medical benefit from today itself. 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

* 1. **For more details contact website of ESIC at** [**www.esic.org.in or cont**](http://www.esic.org.in/)**act 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 Disp. :**
4. **Whether reciprocal Medical arrangements involved, if yes, Please indicate**

**Signature of Branch Manager**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sl.**  **No.** | **Name** | **Date of Birth** | **Relationship with**  **insured person** | **Whether residing with**  **him/her or not** | **If No, State place of**  **Residence** | |
|  |  |  |  | **YES / NO** | **TOWN** | **STATE** |
| **1** |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |