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

1. Insurance No.					
2 Name (in block letters)					
Father's/Husband's Name					
Date of Birth	D	M	Y	Marital Status	M/U/W
				6.Sex	M/F
7. Present Address _____ _____ _____ _____ Pin Code ..... e-mail address		8. Permanent Address _____ _____ _____ _____ Pin Code ..... e-mail address			
Branch Office		Dispensary			

(b) EMPLOYER'S PARTICULARS

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			

(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.							

.....

ESI Corporation
Temporary Identity Card

(Valid for 3 months from the date of appointment)

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).

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 (incase of women employees subject to fulfillment of contributory conditions.
8. For more details Please Visit website of ESIC at WWW.esic.nic.in or 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

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							
2							
3							
4							
5							
6							