



घोषणा पत्र DECLARATION FORM

(A) INSURED PERSON'S PARTICULARS

(B) EMPLOYER'S PARTICULARS

1. Insurance No						
2. Name (in block letters)						
3. Father's/Husband's Name						
4. Date of Birth		Pls. ✓ the appropriate col.	5. Marital Status	MARRIED		
Day	Month			Year	UNMARRIED	
					WIDOWER	
				6. Sex	MALE	FEMALE
7. Present Address			8. Permanent Address			
Pin <input type="text"/>			Pin <input type="text"/>			
Mobile <input type="text"/>			Mobile <input type="text"/>			
e-mail address <input type="text"/>			e-mail address <input type="text"/>			
Branch Office			Dispensary			

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) Emplr's. Code No.					
c) Name & address of the Employer					
Mobile <input type="text"/>					
e-mail address <input type="text"/>					

(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, Mobile & Email

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.							
8.							