

EMPLOYEES' STATE INSURANCE CORPORATION

Declaration Form
(Regulation 11 & 12)

(To be filed in only if the employee has not insured earlier)
Serial No. in return of declaration in Form No:3

Insurance No. Sex		Marital status		Employer's Code no.	
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Name (in block capitals)		Year of birth	
Father's/Husband's name		Date of appointment	
Present Address		Local Office	
Permanent Home Address		Dispensary Age	

(State whether Bachelor, Spinster, Married, Widow or Widower)

N.B. Family particulars are required in duplicate. Please fold TIC below backwards & insert carbon.
Please see overleaf for definition of family particulars

No	Name	Date of birth	Relationship with Insured person	Whether residing with him/her or not
1				
2				
3				
4				
5				
6				
7				
8				
9				

ESIC – T.I.C.O. Valid for 13 weeks from the date of appointment

Insurance no.		Date of appointment	
Name		L.O.	
Name, address & code no. of employer		Dispensary	

Receipt of Identity Card

Received the Identity Card bearing Insurance No. as overleaf

Signature or thumb impression of insured person

Family means the spouse & minor legitimate adopted children dependent on the insured person & his dependants (Sec 2(11) of the ESIC Act, 1948)

Particulars of employment	Whether employed directly through contractor	
	Department	Nature of work

Nomination u/s 50(2) (for females only) and 71 of the ESI Act for payment of any benefit that may be due in the event of death

Name of nominee		Age years
Father's/husband's name		Address
Relationship of the nominee with the insured person		

I affirm that I have NOT been previously insured under the Act & no identity card has been issued to me.
 I hereby declare that the above particulars have been given by me and are correct to the best of my knowledge and belief. I also undertake to intimate to the Corporation any change in the membership of my family within 15 days of such change having occurred.
 Place : Mumbai
 Date of signing the form : _____

Signature or thumb-impression of the employee

Name & address of employer :	Counter signature of employer :
	For

No.	Name	Date of birth	Relationship with Insured person	Whether residing with him/her or not
1				
2				
3				
4				
5				
6				
7				
8				
9				