EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM – 2

ADDITION/ DELETION IN FAMILY DECLARATION FORM

(Regulation 15 B)

Name of the Insured Person ……Insurance No. | |

I declare that the person/ persons whose particulars are given below has/ have now become/ ceased to be member(s) of my family.*

Sl. No.	Name	Date of Birth	Reason(s) for change & date	Relation-ship with the Insured Person	Whether residing with him/her or not, state		If no, where residing		Name of IMP/Disp. attached.
					Yes	No	Distt.	State	

I hereby declare that the particulars given above are true to the best of my knowledge and belief.

Necessary changes may kindly be made in my Declaration Form submitted earlier.

Passport size photographs of the members who are added to family is/ are enclosed.

Place.....

Date .....

…….
Signature/thumb impression of the employee

Particulars of the Employer: -

Name : .....……..

Address: .....……..

.....……..

Code No. .....……..

.....
Name in Block Letters

Countersignature of the employer

.....……..
Designation with Rubber Stamp

Note: "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 unmarried daughter ; (iv) a child who is infirm by reason of any physical or mental abnormality 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).

**Please submit duly attested copy of the Birth/ Death Certificate.*