OPTION FORM FOR REGISTERING MEMBERS OF THE FAMILY FOR AVAILING MEDICAL BENEFIT FROM ESI DISPENSARY/IMP SITUATED IN OTHER STATE.

I _____(Name of the IP) S/W/D/O _____ Ins. No._____ resident of _____ hereby declare that the following members of my family are residing at _____ _____ in _____ State.

They may be allowed to avail medical care from nearby ESI Dispensary / IMP at _____(complete address) till further notice. The address of the Local Office in whose jurisdiction the above said residence falls is _____

I understand that once above option is made, these family members shall receive medical care only from above ESI Dispensary / IMP till the option is changed subject to entitlement.

Sl. No.	Name	Date of birth	Relationship	Remarks if any

Date :

Place : ( )

Countersigned (By employer)

_____

( )

M/s _____

_____