



कर्मचारी राज्य बीमा निगम  
Employees' State Insurance Corporation  
(Ministry of Labour and Employment, Government of India)



श्रम एवं रोजगार मंत्रालय  
Ministry of Labour and Employment  
भारत सरकार (Government of India)

HOME

ABOUT US

WRITE TO US

ACTS

ESI SCHEMES

TENDER

DASHBOARD

PUBLIC GRIEVANCE

## Health Passbook

User-friendly mechanism for beneficiary Identification, recording of clinical findings and consultation advice by the Insurance Medical Practitioner(s)

### Your Treatment Details at a Glance

- Small QR coded booklet with the credential of ESIC beneficiary having photograph affixed on the cover of the Health Passbook duly attested by the Employer/ESIC Branch Manager
- Every family member of the Insured Person is entitled for a Health Passbook
- The Health Passbook is issued to each dependent member of the

Click on Insured Person/Beneficiary

Latest News & Events



Employer Login



Insured Person /  
Beneficiary



Insurance Medical  
Practitioner(IMP)



mEUD



ESIC  
Staff / Pensioner



Lawyer

# IP Portal



कचबेनि  
ESIC  
कर्मचारी राज्य बीमा निगम  
Employees' State Insurance Corporation

## Insured Person/Beneficiary Portal



Language/भाषा: English ▼

### Insured Person / Beneficiary Login

☒ Insured Person ☐ ESI Staff

Username\*

1199900090

Password\*

Ip@1234567

Captcha\*

7bc791

Refresh

7bc791

[Sign Up](#)

[Forgot Password](#)

[IP Portal](#) [Secure](#) [Login](#) [Help](#) [File](#)

Enter login credentials and  
click "Login" button

LOGIN

The Employees' State Insurance Act, 1948,

An Act to provide for certain benefits to employees in case of sickness, maternity and employment injury and to make provision for certain other matters in relation thereto.]



User ID 1199900090

Change Password



Insured Person Details

Language/भाषा: English

Details

Insured Person Name	Subbu a	Insurance Number	1199900090
UHID Number	MH01.0000000001	Date of Birth	03/01/1992
Dispensary Name	Dispensary Azadpur	Disability Type	-- N.A --
Dispensary For Family	Azadpur, DL (ESIC Disp.)	Registration Date	12/05/2015
First Date Of Appointment	01/01/2015	Current Date of Appointment	27/07/2022
Mobile Number	*****1738	Account Number	*****4747

Insured Person

- [Insured Person Details](#)
- [Entitlement to Benefits](#)
- [Contribution Details](#)

Value Added Services

- [ABVKY Claim creation](#)
- [IP Claim Reimbursement](#)
- [Cash Benefit Claim Request Submission](#)

Click on this link to submit the  
Cash Benefit Claim Request



Login User : \*\*\*\*\*



List of Online Certificates uploaded by dispensary/hospital will be displayed here

Online Certificates

S.No	Number	Type	Sub Type	Date/Time of Generation	Request Claim
1	DUMMY000012200044	Maternity Benefit	Expected Confinement	7/27/2022 3:31:06 PM	<a href="#">Click here to raise request</a>

Click on this link in order to raise the claim request

टिप्पणी:

- 1- दावेदार प्रमाणित करेगा कि प्रदर्शित बैंक विवरण सही और वैध हैं जहां दावे के सफल सत्यापन के बाद धन हस्तांतरित किया जा सकता है।
- 2- दावा अनुरोध जमा करने के लिए ऑनलाइन आवेदन केवल तभी किया जा सकता है जब यूएन(UAN) को सीड किया गया हो और बैंक विवरण ईएसआईसी शाखा कार्यालय द्वारा सत्यापित किया गया हो। यह एक बार की गतिविधि है। सहायता के लिए कृपया शाखा कार्यालय से संपर्क करें
- 3- इन प्रमाणपत्रों के खिलाफ ऑनलाइन दावा अनुरोध उत्पन्न किया जा सकता है, यदि पहले से अन्य माध्यमों/मीडिया के माध्यम से जमा नहीं किया गया है।

Footnote:

- 1- The claimant shall certify that the displayed Bank Credentials are correct and valid where the money could be transferred after successful verification of the claim.
- 2- Online application for Claim Request Submission can only be made if the UAN is seeded in ESIC records by the Employer/ESI Officer and the Bank Details have been verified by the ESIC Branch Office. This is an one-time activity. Please contact Employer / Branch Office for assistance in case of updation of Bank Details/ UAN



Login User : 1199900090



Maternity Benefit Claim Request Form (Expected Confinement / Confinement / Miscarriage)

Insured Person's Particulars

Insurance Number:*	1199900090	Name :	Subbu a
UAN Number:*	675433245677	ABHA :	
Date of Issue:	7/27/2022 3:31:06 PM	Name of Branch Office:*	BO - Ajmer Gate
Date of Expected Confinement :*	27/07/2022		<a href="#">Click to view Maternity Benefit Certificate Created by Doctor</a>
Mobile :*	9712781738		

BANK DETAILS OF THE INSURED PERSON AS PER RECORDS

Bank Name:*	ICICI BANK LIMITED	Account Number:*	8437463764747
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☐ I hereby agree to the following-

1- I, the above mentioned Insured Woman, hereby claim Maternity Benefit for expected confinement / confinement / miscarriage (as shown above) with effect from \* 27/07/2022

2- I, further declare that I have ceased / shall cease to work for remuneration with effect from the aforesaid date.

3- I, do hereby give notice that I have taken up / shall take up work for remuneration with effect from the . I have drawn maternity benefit only upto

4- I, do hereby certify that my Bank & other details displayed above are valid, active and correct in all respect and I consent to receive Cash Benefit in this Bank account.

Submit

Cancel

टिप्पणी:

1 - दावेदार प्रमाणित करेगा कि प्रदर्शित बैंक विवरण सही और वैध हैं जहां दावे के सफल सत्यापन के बाद धन हस्तांतरित किया जा सकता है।





Login User: 1199900090

Maternity Certificate details

Maternity Benefit Claim Request Form (Expected Confinement / Confinement / Miscarriage)

Insured Person's Particulars

Insurance Number:\*

UAN Number:\*

Date of Issue:

Date of Expected Confinement:

Mobile :\*

Bank Name:\*

FORM 18 - DOCTOR CERTIFICATE OF EXPECTED CONFINEMENT / CONFINEMENT / MISCARRIAGE

<b>Certificate No.:</b>	DUMMY000012200044	<b>Hospital/Dispensary Name:</b>	test
<b>IP Number:</b>	1199900090	<b>IP Name:</b>	Subbu a
<b>Issue Date:</b>	7/27/2022 3:31:06 PM	<b>Doctor Name:</b>	Mr. Application L ONE
<b>Name of Husband:</b>	Sivaiah A	<b>Confinement Type:</b>	Expected Confinement
<b>Expected Date:</b>	27/07/2022	<b>Remarks by Medical Officer, If Any:</b>	

☐ I hereby agree to the following:

1- I, the above mentioned Insured Person,

2- I, further declare that I have ceased / shall cease to work for remuneration with effect from the aforesaid date.

3- I, do hereby give notice that I have taken up / shall take up work for remuneration with effect from the . I have drawn maternity benefit only upto

4- I, do hereby certify that my Bank & other details displayed above are valid, active and correct in all respect and I consent to receive Cash Benefit in this Bank account.

Submit

Cancel

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Login User : 1199900090



Maternity Benefit Claim Request Form (Expected Confinement / Confinement / Miscarriage)

Insured Person's Particulars

Insurance Number	1199900090	Name :	Subbu a
UAN Number		ABHA :	N/A
Date of Issue		Name of Branch Office:*	BO - Ajmeri Gate
Date of Expected Confinement			<a href="#">Click to view Maternity Benefit Certificate Created by</a>
Mobile :*	9712781738		

BANK DETAILS OF THE INSURED PERSON

Bank Name: ICICI BANK LIMITED

☐ I hereby agree to the following-

- 1- I, the above mentioned Insured Woman, hereby claim Maternity Benefit for expected confinement / confinement / miscarriage (as per medical certificate) from 27/07/2022
- 2- I, further declare that I have ceased / shall cease to work for remuneration with effect from the aforesaid date.
- 3- I, do hereby give notice that I have taken up / shall take up work for remuneration with effect from the [ ] . I have drawn maternity benefit only upto [ ]
- 4- I, do hereby certify that my Bank & other details displayed above are valid, active and correct in all respect and I consent to receive Cash Benefit in this Bank account.

Submit

Cancel

IW need to click on the declaration checkbox to proceed further

Click on Submit button to submit the Claim Request.

टिप्पणी:

1- दावेदार प्रमाणित करेगा कि प्रदर्शित बैंक विवरण सही और वैध हैं जहां दावे के सफल सत्यापन के बाद धन हस्तांतरित किया जा सकता है।





Login User : 1199900090



Maternity Benefit Claim Request Form (Expected Confinement / Confinement / Miscarriage)

Click on Yes button.

Insured Person's Particulars

Insurance Number:*	1199900090	M	Subbu a
UAN Number:*	675433245677		N/A
Date of Issue:	DO YOU REALLY WANT TO SUBMIT YOUR CLAIM REQUEST?		BO - Ajmeri Gate
Date of Expected Confinement :*	<input type="button" value="Yes"/> <input type="button" value="No"/>		<a href="#">Click to view Maternity Benefit Certificate Created by Doctor</a>
Mobile :*	9712781738		

BANK DETAILS OF THE INSURED PERSON AS PER RECORDS

Bank Name:*	ICICI BANK LIMITED	Account Number:*	8437463764747
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☒ I hereby agree to the following-

1- I, the above mentioned Insured Woman, hereby claim Maternity Benefit for expected confinement / confinement / miscarriage (as shown above) with effect from \* 27/07/2022


2- I, further declare that I have ceased / shall cease to work for remuneration with effect from the aforesaid date.

3- I, do hereby give notice that I have taken up / shall take up work for remuneration with effect from the 27/07/2022 . I have drawn maternity benefit only upto 20/10/2022

4- I, do hereby certify that my Bank & other details displayed above are valid, active and correct in all respect and I consent to receive Cash Benefit in this Bank account.

टिप्पणी:

1- दावेदार प्रमाणित करेगा कि प्रदर्शित बैंक विवरण सही और वैध हैं जहां दावे के सफल सत्यापन के बाद धन हस्तांतरित किया जा सकता है।



ESIC  
Employees' State Insurance Corporation

Employee Details

Login User : 1199900090

Maternity Benefit Claim Request Form (Expected Confinement / Confinement / Miscarriage)

Insured Person's Particulars

Insurance Number:*	1199900090	Name :	Subbu a
UAN Number:*	675433245677	ARHA :	N/A
Date of Issue:	BO - Ajmeri Gate		
Date of Expected Confinement :*	<a href="#">Click to view Maternity Benefit Certificate Created by Doctor</a>		
Mobile :*	9712781738		

MATERNITY BENEFIT CLAIM REQUEST HAS BEEN SUBMITTED SUCCESSFULLY!!!

Close

BANK DETAILS OF THE INSURED PERSON AS PER

Bank Name:*	ICICI BANK LIMITED	Ac
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☒ I hereby agree to the following-  
1- I, the above mentioned Insured Woman, hereby claim Maternity Benefit for expected confinement / confinement / miscarriage.  
2- I, further declare that I have ceased / shall cease to work for remuneration with effect from the aforesaid date.  
3- I, do hereby give notice that I have taken up / shall take up work for remuneration with effect from the 27/07/2022 . I have drawn maternity benefit only upto 20/10/2022  
4- I, do hereby certify that my Bank & other details displayed above are valid, active and correct in all respect and I consent to receive Cash Benefit in this Bank account.

Submit

Cancel

Claim Request has been submitted successfully.  
Now click on Close button.  
This claim request will be displayed on Staff Portal

टिप्पणी:

1- दावेदार प्रमाणित करेगा कि प्रदर्शित बैंक विवरण सही और वैध हैं जहां दावे के सफल सत्यापन के बाद धन हस्तांतरित किया जा सकता है।