

**KERALA STATE INSURANCE DEPARTMENT
GROUP PERSONAL ACCIDENT INSURANCE SCHEME**

FORM I
See Section 9(1)

Name of Employee : PEN/KSID ID

Designation :

Office :

To *
.....

I do hereby inform the (Designation of Head of Office) that the person(s) mentioned hereunder shall be my Nominee(s) and that the benefits due to me under the Personal Accident Insurance Scheme to Government Employees and Teachers shall be given to them in the following proportions (in the event of my death or incapacitated to receive the benefit).

Sl. No.	Name of Nominee	Age	Address	Relationship with the member	Proportion of benefits to be given	Contingency under which the nomination becomes ineffective	Person whom the amount is to be given if the nominee is a minor
1	2	3	4	5	6	7	8

Place : Countersigned : Signature :

Date : Head of Office/Head of District Office Name of Employee :

*Officer of the Insured mentioned in Section 5