

**ICBF - LIFE INSURANCE SCHEME
ENROLLMENT FORM**

INSURED DETAILS

Name			Date of Birth	
QID No.			Passport No.	
Mobile No.			Email	
Gender	Male/Female		Nationality	
Association/Company Name				
Permanent Address & Contact No:				

Notes:

Please attach a copy of QID and Passport of the insured member

Premium QAR 125/- (for two years)

NOMINEE DETAILS

Nominee Name:		Relation:	
Nominee Permanent Address:			
Nominee Phone No & Email:			

DECLARATION

I, declare, to the best of my knowledge, that I am in a good health, do not suffer from any disease and I am not undergoing any medical treatment. I agree to the terms and conditions of the Policy. I also hereby authorize to disburse the policy amount to the nominee mentioned above in case of any incident and indemnify ICBF from any legal responsibility whatsoever.

Name: _____ Date: _____ Signature: _____

For Official Purpose only:

Verified:	Insurance Reg. No:
	Status:

Facilitator

Indian Community Benevolent Forum (ICBF)

Damaan Islamic Insurance Company (Beema)
Health Questionnaire

Name _____ Civil ID _____

1. Have you ever had, or been told to have or been treated for, or will be receiving medical advice, counseling, or treatment in connection with the following conditions:		
	No	Yes
a) Raised cholesterol, blood pressure, chest pain, diseases of or any disorders of the heart or blood vessel disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) Diabetes mellitus, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
c) Cancer, tumors, growth, lump, cyst, of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
d) Diseases or disorders of kidney (e.g. blood, sugar in urine), stomach, intestines, liver, gall bladder, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
e) Ear(s), eye(s), nose, throat, asthma, persistent cough, breathing discomfort or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>
f) Fits, paralysis, stroke, weakness of the limbs, depression, or any other nervous or mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g) Arthritis, rheumatism, gout, joint, back or other bones and joints problems, loss of use of limb, physical deformity or disability?	<input type="checkbox"/>	<input type="checkbox"/>
h) HIV and/or AIDS related condition or any infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
i) Any other illness or disease not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past two years, have you suffered from a sickness or involved in an accident for which you were admitted to hospital or medical center or undergone an operation?	<input type="checkbox"/>	<input type="checkbox"/>

DECLARATION

I declare, to the best of my knowledge, that the above declarations I made are complete and true and I have not willfully attempted to avoid disclosing information which would have a bearing on the terms of the Cover applied.

I also agree that, if it is proven that there is non-disclosure of material fact that I know or ought to know, the Cover effected will automatically be voided or cancelled.

Signature _____

Date _____