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 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?	☐	☐
b) Diabetes mellitus, thyroid disorders or any other endocrine disorders?	☐	☐
c) Cancer, tumors, growth, lump, cyst, of any kind?	☐	☐
d) Diseases or disorders of kidney (e.g. blood, sugar in urine), stomach, intestines, liver, gall bladder, or blood?	☐	☐
e) Ear(s), eye(s), nose, throat, asthma, persistent cough, breathing discomfort or any other lungs disorders?	☐	☐
f) Fits, paralysis, stroke, weakness of the limbs, depression, or any other nervous or mental disorders?	☐	☐
g) Arthritis, rheumatism, gout, joint, back or other bones and joints problems, loss of use of limb, physical deformity or disability?	☐	☐
h) HIV and/or AIDS related condition or any infectious disease?	☐	☐
i) Any other illness or disease not listed above?	☐	☐
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?	☐	☐

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**