DSBT – FAMILY BENEFIT SCHEME

Application Form

(To be filled in Block letters)

Affix your recent passport size photo attested by Local Branch secretary

(For Office use only)

FBS no:
R. No:
Date:

Name of the Doctor in full: _____

Name of Father/ Spouse: _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ **Age:** ☐☐ years **Sex:** M ☐ F ☐
Date Month Year Please Tick.

☐ Please Tick communication address.

Clinic / Office Address:

_____

_____

_____

Pin code: _____

Land Phone (add STD Code) _____

☐

Residential address:

_____

_____

_____

Pin code: _____

Land Phone (add STD Code) _____

Mobile phone: 1. _____ **2.** _____

E-mail address: 1. _____ **2.** _____

IDA Life /Annual membership number: _____ **Local branch:** _____.

Specialty Dental Association: _____ **Life membership No.** _____.

I, Dr._____, the undersigned hereby apply for the Membership of DSBT- Family Benefit Scheme. I enclose here with Transaction ID of my payment_____Dated: _____ (OR) D.D No._____ for Rupees _____ Dated _____ drawn on (Bank)_____being the payment towards contributory deposit of the scheme as per my age and all the other necessary documents.

I do hereby declare that the above information is true and I have not withheld any information whatsoever regarding my particulars and my membership can be terminated if any information is found to be incorrect. I agree to pay the Fraternity Contributions as per the rules and regulations of this Scheme.

I, further agree to abide by all the rules & bye-laws of DSBT - "Family Benefit Scheme" and also any amendments to be made from to time in the constitution/bye-laws by Management committee of FBS. I will not proceed legally against DSBT - Family Benefit Scheme, without going to the Arbitration Committee of the FBS. Any change of my address will be informed to FBS office from time to time.

Date:

Place:

_____
(Signature of the Applicant)

Health Declaration by Applicant

(For Admission to DSBT - Family Benefit Scheme)

I hereby declare that I am not suffering from any following Mentioned diseases:

1. Malignancy – Primary / Secondary:
2. Serious Heart Problem – underwent By-Pass Surgery or Angioplasty for Coronary Artery Disease:
3. Serious Neurological diseases and Brain Diseases:
4. Serious Kidney diseases:
5. Liver Disease like Cirrhosis:
6. Serious Bone Diseases:
7. Degenerative Diseases:
8. Severe Diabetes and/or grade III Hypertension:
9. Immuno-compromised diseases:
10. Any other serious illness

I, do hereby declare that the above information is true and I have not withheld any information whatsoever regarding my health particulars and my **DSBT - Family Benefit Scheme** Membership can be terminated if any information is found to be incorrect and benefits of the **DSBT - Family Benefit Scheme** need not be paid to my nominee/s. **Failure to inform above will lead to non-payment to my Nominee/s or legal heir/s.**

Date:

Place:

_____

(Signature of Applicant)

Certificate of Local Branch

This is to certify that Dr._____with IDA Membership No./ Specialty Dental Association No._____is a Member of IDA Local Branch /Specialty Dental Association_____.

The information declared by the member is true and all the rules & bye-laws of DSBT - "Family Benefit Scheme" were explained to him.

It is the duty / responsibility of the member to inform about any change of his / her address to the office of FBS from time to time.

Date:

Branch:

Local branch seal

_____

Secretary/ President

_____

Signature of Local branch FBS representative

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NOMINEE FORM

S. No	Name of the Nominee	D O B of the Nominee	Relationship to the Member	Whether sole Beneficiary or Mention % of Benefit to each of Nominee/s	Specimen Signature of Nominee / Guardian	Stamp size photograph of the nominee

Note:

1. If the nominee is a minor, please affix the photograph of the minor with the Signature of the Parent / Guardian.
2. If by any reason, nominee is not alive, then the benefit will be paid to legal heir of the member.

Witness:

1. Local Branch Secretary / President: **Name _____ Signature_____**

2. Local Branch FBS Representative: **Name _____ Signature_____**

Enclosures:

1. Demand Draft / Payment transaction details Drawn in favor of Dental surgeon Benefit Trust, payable at Vijayawada.
2. Proof of Life / Annual Membership of IDA / Specialty Dental Association.
3. Copy of State Dental Council Registration Certificate
4. Proof of Age. (Copy of PAN card / Driving license / Passport / Date of Birth Certificate)
5. Aadhar Card copy

Place :

Date :

_____

Signature of Applicant

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IDENTITY CARD

Photograph

of the Member

Name of the Doctor: _____

Date of birth ☐☐ ☐☐ ☐☐☐☐

Date Month Year

Address:

_____

_____. Pin: _____

IDA Life / Annual Membership No: _____Local branch: _____ / A.P State branch.

Specialty Dental Association: _____ Life membership No. _____

Date of joining FBS:_____.

Signature of DSBT Chairman

Signature of DSBT Treasurer

Back side ***Back side***

1st Nominee Photo

2nd Nominee Photo

3rd Nominee Photo

Signature of DSBT Secretary

Signature of member

PROPERTY OF DSBT, IF FOUND RETURN TO:

The Chairman / Secretary,

DSBT - Family Benefit Scheme,
Door No-29-19-79, Above Indian Bank,
Dornakal Road, Suryaraopet,
VIJAYAWADA-520002. PH: 0866-2433444
familybenefitscheme@gmail.com