



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 time 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:

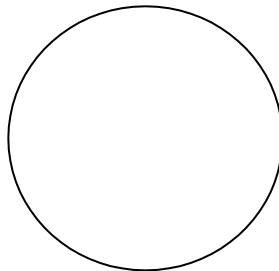
(Signature of Applicant)

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