SOCIAL DECLARATION FORM

COLLEAGUE DETAILS					
COLLEAGUE NAME:				PASSPORT #:	
POSITION:				DEPARTMENT:	
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	
NATIONALITY:				RELIGION:	
MARITAL STATUS:	☐ SINGLE ☐ MARRIED	☐ DIVORCED ☐ WIDOWED		CHILDREN:	
FATHER'S NAME:				NATIONALITY:	
MOTHER'S NAME:				NATIONALITY:	
SPOUSE DETAILS					
SPOUSE NAME:					
EMPLOYER:				OCCUPATION:	
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	
CHILDREN DETAILS					
CHILD NAME:					
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	
CHILD NAME:					
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	
CHILD NAME:					
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	
CHILD NAME:					
UAE RESIDENCE VISA:	☐ YES ☐ NO	GENDER:	☐ M ☐ F	DATE OF BIRTH:	

BENEFICIARY DETAILS

I hereby confirm that in the event of death, my beneficiaries to whom any amounts are due under the Company Life Insurance Scheme, should be paid to the following:

NAME	RELATIONSHIP	PERCENTAGE (%)

Colleague Signature: Date: