



# FAMILY BENEFIT SCHEME OF PPLSSS OF IMA TAMILNADU



## MEMBERSHIP APPLICATION FORM

1. Name (in Capital Letters) : Dr. \_\_\_\_\_

2. Date of Birth : \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male/Female

3. Father's / Husband's Name : \_\_\_\_\_

4. Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Pin code: \_\_\_\_\_

5. Telephone No. : Resi: \_\_\_\_\_ Hosp : \_\_\_\_\_ STD Code: \_\_\_\_\_  
Mobile No. \_\_\_\_\_ E-Mail: \_\_\_\_\_

6. Qualification	Name of the University	Year of Passing
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Registration No. : \_\_\_\_\_ Year of Registration \_\_\_\_\_  
Name of the Medical Council : \_\_\_\_\_

8. Present Place of Practice : \_\_\_\_\_

9. IMA Life Membership No : \_\_\_\_\_

10. Name of the Local Branch : \_\_\_\_\_

11. PPLSSS No : \_\_\_\_\_

12. Are you insured under indemnity Scheme : Yes / No  
If Yes, Name of Insurance Company : \_\_\_\_\_  
Place: \_\_\_\_\_ Policy No. \_\_\_\_\_ Date of Expiry: \_\_\_\_\_

13. Name of the Family Members	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Nominee Name	Age	Sex	Relationship
_____	_____	_____	_____