Photo Duly attested by Local Ima Brach Secretary

FAMILY BENEFIT SCHEME
OF
A.P STATE BRANCH OF IMA

REGULAR SERIES

(For Office Use Only)

Proposed by Dr. ……..

FBS member of ……Branch of IMA

IMA L.M. NO……

FBS No. :

R.No. :

Date :

FORM OF APPLICATION

(TO BE FILLED IN BLOCK LETTER)

SURNAME :……

FIRST NAME :……

NAME OF FATHER/HUSBAND : ……

DATE OF BIRTH :……..

AGE : ……..SEX ……..

QUALFICATION : ……

NAME OF LOCAL BRANCH :……..

OF IMA

CORRESPONDENCE ADDRESS:

…….

…….

PHONE:……

PERMANENT ADDRESS

……

……

PHONE:……

1.The undersigned hereby apply for the Membership of Family Benefit Scheme of Andhra Pradesh State Branch of I.M.A., I enciose here with D.D.No……for Rs. ……(Rupees……) Dated ……drawn on…… being the relevant fee and caution deposit. I do here by declare that

above information is true and I have with held no information whatsoever regarding the application and I agree to pay the demanded amount as per the Rules of this Scheme.

I further agree to abide by all the conditions laid down in the Constitution of the Scheme and the amendments to be made from time to time.

Date…….. ……

(Signature)

NB: 1. Only demand draft payable at Hyderabad will be accepted.

2.Demand draft for to be drawn in favour of Secretary, Family Benfefit Scheme of A.P state Branch of I.M.A.

3.Proof of life Membership of IMA: Copy of life Membership Certificate Identity card from Head Quarters / enrolment letter from state Branch of IMA / receipt of Life Membership Subscription paid to the local branch (accepted Subject to verification from the State office) should accompany this form

4.Proof of date of birth – certified copy of S.S.c, or matriculation certificate should accompany the application from

NOMINATION FORM

S.No.	Name For The Nominee (and Guardian if nominee is minor)	Date Of Birth Of the Nominee	Relation Ship to the member	Thumb Impression & Specimen Signature Of Nominee Guardian	Address	Stamp Size Photograph Of Nominee

CERTIFICATE

This is to Certify That Dr. _____ is a life member of

_____Branch of ima from _____

Forwarded to the Secretary , Family Benefit Scheme of A.P. State , I.M.A.

Date _____ _____

SecretaryPresident

(Rubberstamp Of Local Brach Compulsary)

Branch _____

Voluntary Health Declaration

1.Dr. _____ Member Of _____ Branch I.M.A. applying for the membership of FBS of A.P. state IMA here solemnly affirm and declare that to the best of my knowledge. I am not suffering From any chronic disease(s) like diabetics /hypertension/sehernic heart disease/cerebrovascular accidents .

Witness Signature……

1…… Name & address…….

2…… ……..

If the Nominee is minor, name of the person who represents the minor and his/her address:

Date of Birth and age of minor:

Specimen Signature Of Nominee or minor's representative and Thumb Impression:

I here by declare that the above information furnished by me and correct Signature of member