# PROFESSIONAL PROTECTION LINKED SOCIAL SECURITY SCHEME 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

| 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. Category Applied : GP / Non Surgical Specialist / Surgical & Anesthetist
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

| Name of the Family Members | Age | Sex | Relationship |
|---|---|---|---|
| ________________ | ______ | ______ | __________ |
| ________________ | ______ | ______ | __________ |
| ________________ | ______ | ______ | __________ |
| ________________ | ______ | ______ | __________ |

14. Nominee Name Age Sex Relationship

| Nominee Name | Age | Sex | Relationship |
|---|---|---|---|
| ________________ | ______ | ______ | __________ |

15. Payment Details :

DD No. __________ Bank _____________________ Branch ______________

Amount __________________ Date of Issue __________________

Payment options DD

DD should be send in the name of “**PPLSSS OF IMA TN**” Payable **at Omalur**

Send the filled up application along with payment information

**Dr. P. Manivannan, M.B.B.S, D.ORTHO.,** Hony.Secretary, PPLSSS of IMA TNSB.

Sri Sugam Hospital (1st Floor), 149- E1,Bazaar Street, Omalur (PO), (TK), Salem - 636 455.

Mob:9487272627, Ph:04290-290455

Dispatch Details : Date _________ Courier/Registered Post/ in person

Date of commencement of membership will be from the date of receipt of DD at the principal office.

**DECLARATION**

I, ______________________________ _______a Life Member of __________________ Branch of IMA, do hereby, declare that the details furnished above are true and correct and that I will abide by the Rules and Regulations of Professional Protection Linked Social Security Scheme of IMA Tamilnadu as amended on 01.3.1998.

**I hereby authorize PPLSSS office to send Membership alerts via SMS and e-mail.**

Date: Signature

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**Not For Renewal Members**

Forwarded: _________________

Designation: _________________

(To be forwarded by the local branch President/Secretary/PPLSSS District Co-ordinator)

Signature: _________________

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**(FOR OFFICE USE ONLY)**

Date of Receipt :

Mode of Receipt : Courier/Reg.Post/in person (Time: a.m/p.m)

Application Form : Complete/ Incomplete Remarks:

D.D. Realised on :

Date of Commencement of Membership :

Date of Despatch of PPLSSS Receipt to the member :

Date of Despatch of PPLSSS Certificate to the member :

PPLSSS Membership No: