FAMILY BENEFIT SCHEME

OF PPLSSS OF IMA TAMILNADU

NEW 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. _____ WhatsApp 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

_____ _____ _____ _____

15. Payment Details :

DD No. _____ Bank _____ Branch _____

Amount _____ Date of Issue _____

Payment options DD

DD should be taken in the name of "**FBS of PPLSSS of IMA TN**" Payable **at Kumbakonam**

Send the filled up application along with payment information to
Dr. P. Lenin., Hony.Secretary, PPLSSS of IMA TNSB.
Sugam Multi-Speciality Hospital, Room No.301 - 3rd floor, No.1 New Railway Station Road,
Kumbakonam - 612001. Mob: 9487272627, 9443070902

Despatch 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

Not For Renewal Members

Forwarded by: _____

Designation: _____

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

Signature: _____

(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 Receipt to the member :

Date of Despatch of Certificate to the member :

FBS Membership No :

Renewal Due on :

Letter of reminder sent on :

Renewal Fee received on :

HIGHLIGHTS OF FBS

- **Scheme shall reimburse Rs. 1.2 lakh for the Hospitalization expenses incurred in that year for the member, spouse or children below 18 years and not exceeding Rs. 60,000/- per Hospitalization for the members or their nominee.**
- **The member has to inform the scheme office about the hospital of his / her choice for elective surgery before admission.**
- **Member has to inform the scheme office within 24 hours of admission in emergency cases.**
- **Claim must be made within 30 days after the discharge.**
- **Original bills and discharge summary are to be produced along with the claim form.**

FBS NEW

SUBSCRIPTION AMOUNT			
	ANNUAL FEE		
AGE	AMOUNT Rs.	GST (Rate 18%) Rs.	TOTAL Rs.
Upto 45 years	3500	630	4130
46 - 55 years	4500	810	5310
56 - 60 years	5500	990	6490

NOTE : FBS NEW MEMBERS ENTRY UPTO AGE 60 YEARS ONLY

Payment options DD. DD should be taken in the name of "FBS of PPLSSS of IMA TN" Payable at Kumbakonam