Photo Duly attested by
Local IMA Branch
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 LM.No----------

FBS NO. :

R.NO. :

DATE :

FORM OF APPLICATION
(TO BE FILLED IN BLOCK LETTERS)

SURNAME :----------

FIRST NAME :----------

NAME OF FATHER/HUSBAND :----------

DATE OF BIRTH :----------

AGE :---------- ----------SEX----------

QUALIFICATION :---------- ----------

NAME OF LOCAL BRANCH
OF IMA :----------

CORRESPONDENCE ADDRESS :

PHONE:----------

PERMANENT ADDRESS

PHONE:----------

I, the undersigned hereby apply for the Membership of Family Benefit Scheme of Andhara Pradesh State Branch of I.M.A., I enclose 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 Benefit 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 form.

NOMINATION FORM

Name fo the Nominee (and Guardian if the Nominee is Minor)	Date of Brith Of the Nominee	Relationship to the Member	Thumb impression & Specimen Signature of the Nominee/Guardian	Address	Stamp Size Photograph of the Nominee

CERTIFICATE

This is to certify that Dr.----------is a Life Member of

----------branch of I.M.A. from ----------

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

Secretary/President
(Rubber Stamp of Local Branch Compulsory)
----------Branch

VOLUNTARY HEALTH DECLARATION

I Dr.---------- member of ----------Branch of I.M.A. applying for the membership of FBS of A.P. State IMA do
y solemnly affirm and declare that to the best of my knowledge I am/am not suffering from any chronic disease (s) like Diabeties/Hypertension/Ischemic heart disease/Cerebrovascular accidents or Cancers.

ess:

Signature----------

1.----------

Name & Address----------

2.----------

ATTESTED:
Hony.Secretary
I.M.A.----------Branch

nominee is a minor, name of the person who represents the minor and his/her address :
of birth and age of Minor :
men Signature of the nominees or Minor's representive and Thumb impression :

by declare that the above information furnished by me is true and correct.

Signature of Member