INDIAN MEDICAL ASSOCIATION KERALA STATE BRANCH

IMA KERALA HEALTH SCHEME

APPLICATION FORM

E mail: imakeralahealthscheme@gmail.com, imaksbhs@gmail.com Web- imakhs.com Tel.9539332426

R No	
R. Date	
En.Date	

EN. NO	IF ALREADY A MEMBER	OFFICE USE	OFFICE USE	OFFICE USE	OFFICE USE

MEMBER

Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			
Med Council Reg. No	Year	Name of Council	
Qualifications			
IMA Life membership No			

SPOUSE

Spouse -Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			
Med Council Reg. No	Year	Name of Council	
Qualifications			
IMA Life Membership No (if ima member)			

PARENTS IF WANT TO JOIN

Father - Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			

Mother-Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			

CHILDREN IF WANT TO JOIN

Son/ Daughter Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			

Son/ Daughter Name			
Age	DOB D D M M Y Y Y Y	Date of Birth Proof Document	
Address Permanent	Pin	Address Communication	Pin
Mob		Tel with STD Code	
E Mail ID			

Nominees	Name	Relation	Signature
1			
2			
3			

DETAILS OF PAYMENT

Cheque ☐ DD ☐

Amount ....NO ....DATE..............................

Name of Bank..Branch ....

AFFIDAVIT

I ....hereby state that the details furnished by me are true to the best of my knowledge and I am in sound state of mind and body. I further state I shall abide by the rules and regulations of the scheme which may be amended from time to time (if need arises).

Date Signature of the Applicant

CERTIFICATE FROM BRANCH PRESIDENT / SECRETARY

I, DR .... PRESIDENT/ SECRETARY OF IMA ....

BRANCH DO HERE BY CERTIFY THAT DR...IS A LIFE / ANNUAL MEMBER OF THIS BRANCH

DATE SEAL SIGNATURE

Submit the Application form duly filled in and singed along with

1. Date of Birth proof Document Copy
2. Copy of IMA Life Membership Certificate / Card
3. Cheque/DD payable at Kozhikode Drawn in Favour of **IMA KERALA HEALTH SCHEME**

To Dr. Jayakrishnan B, Secretary IMA KHS, Safe Care, Tirur - 676102

Tel. & Whatsapp No: 9539332426, 9387119618 Email: imaksbhs@gmail.com, drjay@safecare.in

FOR OFFICE USE ONLY

DATE OF APPLICATION	D	D	M	M	Y	Y	Y	Y
APPLICATION RECEIVED	D	D	M	M	Y	Y	Y	Y

ENROLLMENT NO.	RECIEPT NO

VERIFICATION DATAILS FROM STATE HQ

LIFE		ANNUAL		NON MEMBER	

DD/CHQ ENCASHED	YES		NO		REPAID	

DATE OF ENROLMENT	D	D	M	M	Y	Y	Y	Y
HEALTH CARD SENT ON	D	D	M	M	Y	Y	Y	Y

SIGNATURE SECRETARY IMA KHS