



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 Dharmapuri

Send the filled up application along with payment information to

Dr. M.Chandrasekar., Hony.Secretary, PPLSSS of IMA TNSB.

Prahadeesh Hospital, 66/27, South Railway Line Road, Kumaraswamy Pettai, Dharmapuri - 636701.

Mob: 9487272627, 9150515253

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

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