



**INDIAN MEDICAL ASSOCIATION'S**  
**KARNATAKA PROFESSIONAL PROTECTION SCHEME (R) -KPPS**  
Registered Office: IMA House, AV Road, Chamrajpet, Bangalore-580018.  
**Ph: 080-26705447 – KPPS Mobile : 9141546924**  
Email: [imakpps@gmail.com](mailto:imakpps@gmail.com) Web- [www.imakppsbengaluru.org](http://www.imakppsbengaluru.org)

**Documents to be attached:**

1. Duly filled and signed application form.
2. IMA Life membership certificate (Xerox copy).
3. KMC Registration Certificate (Xerox copy)
4. Address proof–Aadhar /Voter ID. (Xerox copy)
5. Pan card. (Xerox copy)
6. One Passport size photo.

**Note:** a) At par Cheque/DD to be drawn in favor of **IMA KPPS**  
b) Duly filled applications to be sent to registered office address mentioned above.

PHOTO

***For office Use  
Only***

IMA-KPPS No:	Receipt No.	Folio No:
Branch:	Date:	
Date of Provisional Admission:		

**APPLICATION FORM- (To be filled in Block letters)**

First Name & Surname : \_\_\_\_\_

Father's / Husbands Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Specialty of Practice: \_\_\_\_\_

Clinic / Hospital / Institution Name: \_\_\_\_\_

Address of Practice: \_\_\_\_\_

Date of Birth: 

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 Age: Years 

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 Months 

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Sex: Male 

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 Female 

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KMC Regn. No: \_\_\_\_\_ Date of Regn: \_\_\_\_\_ PAN No: \_\_\_\_\_

IMA Life Membership No: \_\_\_\_\_ IMA Branch: \_\_\_\_\_

Do you Have Professional Indemnity from any other Company. Yes / No

If yes give details:

Company: \_\_\_\_\_

Indemnity Amount: \_\_\_\_\_

CORRESPONDENCE POSTAL ADDRESS	PERMANENT POSTAL ADDRESS
PIN:	PIN:
<b>FOR E-COMMUNICATION</b>	
Phone No: Residence-	Hospital - STD Code-
Mobile No:	
Email id in CAPITAL Letters:	

**I the undersigned hereby apply for the membership of IMA's Professional Protect Scheme.**

I have enclosed **DD/ Cheque /Online with No/UTR No** \_\_\_\_\_

drawn on Bank \_\_\_\_\_ Branch \_\_\_\_\_

Dated \_\_\_\_\_ for Rs \_\_\_\_\_ in words \_\_\_\_\_

**I do here by declare that the above information is true to the best of my knowledge and belief and that I have not withheld any information what so ever regarding my particulars. My membership from the scheme may be terminated if any information given is found to be incorrect or submission of any false information in the application form for joining the scheme or in subsequent communication. I further state that I am in sound state of mind & I agree to pay the Fraternity Contribution as per the rules of the scheme from time to time. I will abide by the constitution and bye-laws of IMA KPPS and amendments made from time to time in the constitution and bye-laws in future. I accept that any decision of the Managing Committee as final. I also accept the legal jurisdiction of the IMA KPPS as Bangalore & Continuation of the IMA KPPS membership is mandatory for claiming the benefits under this scheme.**

**Date:** \_\_\_\_\_

**Place:** \_\_\_\_\_

**Signature of the Applicant**

Motivated by (IMA / KPPS Member) \_\_\_\_\_

Life member of \_\_\_\_\_ branch do hereby recommend

Dr. \_\_\_\_\_

Life member of \_\_\_\_\_ Branch to become the member of IMA'S KPPS.

**Seal of Local branch**

**Signature of Local Branch President / Secretary/IMA'S KPPS MC Member**

**This page can be retained by the member**

## **IMA KARNATAKA PROFESSIONAL PROTECTION SCHEME**

### **SUBSCRIPTION FEE DETAILS**

FEE DETAILS FOR THE ADMISSION		
1.	Admission Fee	Rs. 100/-
2.	Annual Subscription Fee	Rs. 2000/-
3.	Advance Fraternity Contribution	Rs. 1000/-
4.	GST 18% & Round off to	Rs. 600/-
5.	<b>Grand Total</b>	<b>Rs. 3700/-</b>
FEE DETAILS FOR SUBSEQUENT YEARS		
1.	Annual Subscription Fee	Rs.500
2.	Demand Fraternity Contribution	Premium Notice will be sent to all the members on or Before 1st April of every year

**For Payment to IMA KPPS use this QR code**

**OR**

**To Account Number : 57035376153 IFSC Code: SBIN0070242**

**It's Mandatory to send the details of Payment like Your Name & UTR number to**

**KPPS Mobile: 9141546924**

INDIAN MEDICAL ASSOCIATION

**SCAN & PAY**



UPI ID: 57035376153@sbi