



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 Web- 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:

--	--	--	--	--	--	--	--

Age:

Years

Months

Sex: Male

☐

Female

☐

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:
FOR E-COMMUNICATION	
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 with 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

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.	Grand Total	Rs. 3700/-
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.
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