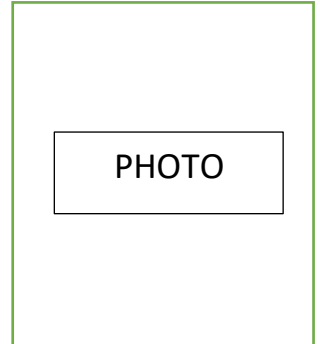


MEDINS LEGAL



LEGAL AID FOR MEDICAL PROFESSIONALS

MEMBERSHIP REGISTRATION FORM

Date-

PARTICULARS-

Full Name- _____

M/s/ Dr.- _____

Father's/Husband's/Owner's Name- _____

Contact Number- _____ Alternate Contact Number- _____

E-mail Id- _____ Date of Birth (DD/MM/YYYY)- _____

Name of Clinic/Nursing Home/Hospital/Lab- _____

Address- _____

PIN- _____ City- _____ State- _____

Qualification- _____

Name of the Association enrolled if any- _____

Medical Registration Number- _____

Existing policy or membership with any insurance company (Yes/No) (If yes, name of the insurance policy)- _____

Sum insured- _____ Any claim experience- _____

Any claim experience -If yes; please share the brief description about the nature and stage of litigation (this detail is required if you wish to have our membership for non-medico legal cases as well)- _____

If you wish to take membership for any colleague doctor operating from your clinic, please share his/her name with educational qualification- _____

If you wish to have membership for any other qualified staff/nurse/compounder/health worker working in your clinic? If yes, please share the details- _____

Nominee- _____

Any other information- _____

PAYMENT DETAILS-

| DATE | DRAWN ON | CHEQUE NO./DD/NO | AMOUNT | NOTES |
|------|----------|------------------|--------|-------|
| | | | | |

As per Services of Medins Legal I hereby voluntarily declare to be a member of Medins Legal for which I deposit Rs. _____ for _____ year/s and I am quoting my details above.

