REGISTRATION FEE: GH¢ 5.00 ADD 2 PASSPORT PICTURES

GHANA MEDICAL ASSOCIATION FUND

MEMBERSHIP APPLICATION FORM

Name...

Permanent Address..

....

Tel: .... Fax: .... Email: ....

Date of Birth: .... Planned Retirement Age: ....

Occupation/Specialty...

Employer (Please tick)

☐ Self Employed ☐ Government Institution ☐ Private Institution

Name and Address of Institution:

....

Monthly Contribution

☐ GH¢ 200.00

Beneficiaries

Name	Relationship	Percentage (%)
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....

I hereby apply to be a member of the GMA Fund. I confirm that I have read the rules governing the operations and management of the Fund as at present in force and agree to abide by them.

I undertake to make regular contributions at the rate prescribed by the Rules of the Fund and by a mode of payment approved by the Board of Directors.

Signature: .... Date: ....