# INSTITUTE FOR HEALTH INSURANCE AND MANAGED CARE OF NIGERIA

## ASSOCIATE FORM

Passport photo.

Please tick ☐ Certificate ☐ Associate ☐ Ex.certificate

First Name | Other Names | Surname

Name of Organisation

Residential Address

DOB | Nationality | State | Telephone

Institute Registration Number | Active E-mail

Name of Next of Kin

Academic & Professional Qualifications

**Declaration;**

I declare that to the best of my knowledge, the information given above is accurate

Signature._____

Thumb Print

Date.