



# INSTITUTE FOR HEALTH INSURANCE & MANAGED CARE OF NIGERIA

00018



## EXECUTIVE MEMBERSHIP FORM

Passport  
Photo.

Mr./Mrs./Dr./Prof/Hon.	First Name	Other Name	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: \_\_\_\_\_

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