GMS
AUTHORISATION FORM

Primary Care Reimbursement Service
Exit 5, M50,
North Road,
Finglas, Dublin
11.

NAME: _____

ADDRESS: _____

_____

_____

GMS NO: _____

I hereby authorise the Primary Care Reimbursement Service to deduct my monthly IMO Subscription per month with effect from …….

Yours sincerely,

SIGNED: _____ DATE:_____

I consent to IMO Financial Services contacting me regarding the financial products and services available to me as a members of the IMO which may be of interest to me. If you wish us to forward your contact details to IMOFS and be contacted by IMOFS in writing, by email, by landline and mobile phone, SMS text and fax electronic, please tick this box:

☐