POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Member Record Amendment

Email: polmedmembership@medscheme.co.za • Fax: 0861 888 110

PLEASE NOTE: It is compulsory to complete ALL sections of the application form, especially those marked with an asterisk (*). If all compulsory sections are not completed, your application may not be processed.

TO BE COMPLETED IN BLOCK LETTERS AND SENT TO MEMBERSHIP AND CREDIT CONTROL DEPARTMENT.
If you require assistance in completing this form, please contact the POLMED Client Service Call Centre on **0860 765 633.**

Personal Membership Details*

Membership Number* ☐☐☐☐☐☐☐☐☐☐☐☐☐

Initials _____ Title/Rank (Mr, Mrs, Miss) _____ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Surname _____

First Name (in full) _____

Contact Details*

New Postal Address (where mail is received) _____

_____

_____ Code _____

Telephone (Home) _____ Telephone (Work) _____

Cellphone _____ Fax _____

Email _____ Date on which change will become effective D D M M Y Y Y Y

Change of Unit

Station _____ Unit _____

Postal Code where Station/Unit is Located _____ Effective Date D D M M Y Y Y Y

SAPS Area _____ Province _____

Member - Advice of Change of Marital Status

Please mark the appropriate box with an "X". ☐ Married ☐ Divorced ☐ Widow(er)

If Married: Spouse: Initials _____ Title/Rank (Mr, Mrs or Miss) _____

New Surname (if applicable) _____

Date of Marriage/Divorce/Death D D M M Y Y Y Y

Spouse ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ My spouse is not a member of another medical scheme ☐ My spouse is employed

Name of Company _____

☐ My spouse is a member of a registered medical scheme Name of medical scheme _____

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Please supply this office with the following documents in case of:

Marriage: Certified copy of membership certificate issued by the Department of Home Affairs and copy of ID.
Divorce: Certified copy of decree of divorce and a complete copy of settlement stating that the member is responsible for the medical costs of the children.
Death: Certified copy of death certificate.

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Deletion of Dependants

Please note: In the case of divorce, legal documentation is required.

1. Surname of Dependant _____ Relationship _____

Initials _____ Title (Mr, Mrs, Miss) _____

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Effective Date D D M M Y Y Y Y

Reason _____

2. Surname of Dependant _____ Relationship _____

Initials _____ Title (Mr, Mrs, Miss) _____

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Effective Date D D M M Y Y Y Y

Reason _____

Death of Member

Please note: An application form for continuation membership must be completed by widow/er/orphan.

Date of Death D D M M Y Y Y Y **Please supply this office with a certified copy of the death certificate.**

Termination

Reason _____

Postal Address _____

_____

_____ Code _____

Telephone (Home) _____ Fax _____

Cellphone _____ Date of Resignation/ Retrenchment D D M M Y Y Y Y

Would you like to continue your membership with POLMED? YES NO

Declaration and Authorisation

I hereby declare that the statements are true and correct, and that no information has been wilfully withheld. I accept that the nominated dependant(s) will be bound by the rules of the Scheme.

Signature of Applicant _____ Date D D M M Y Y Y Y