POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Membership

Please note: It is compulsory to complete All sections of the application form to prevent delays in processing your application.
Please supply the following documents if applicable:
Member: copy of ID.
Marriage: copy of marriage certificate issued by the Department of Home Affairs or customary union certificate and copy of ID.
Biological baby/children born out of wedlock: copy of full birth certificate and an affidavit stating that the member is the biological parent of the child.
Bank account details: copy of most recent bank statement or stamped letter from bank confirming bank details.

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

Member Details

Persal Number _____ Plan selection ☐ Aquarium

Surname _____

First Names (in full) _____

Initials _____ Title/Rank _____

Identity Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

Marital status (If divorced attach a copy of final order of divorce with the addendums, if any)

Gender Male Female

☐ Married ☐ Single ☐ Widow/er Date of marriage/divorce D D M M Y Y Y Y

Which category describes you? ☐ Asian/Indian ☐ Black ☐ Coloured ☐ White

Residential Address _____

_____ Code _____

Postal Address _____

_____ Code _____

Province _____ Cluster _____

Please indicate where you wish to receive your correspondence ☐ Email ☐ SMS ☐ Residential Address ☐ Postal Address

Tel (Home) _____ Tel (Work) _____

Email _____ Fax _____

Cellphone _____ Is your cellphone web-enabled (WAP) ☐ Yes ☐ No

Details of Dependant(s)

No person may belong to different medical schemes at the same time.

Surname	Full First Name	ID Number	Current SAPS employee (Y/N)		Relationship (e.g son/daughter)	Gender	
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐

POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Membership

Next of Kin's Details

Surname and initials _____

Postal Address _____

_____ Code _____

Cellphone _____

Email _____

Relationship to principal member, e.g mother/spouse _____

Income Category

Please indicate your basic monthly salary/income (include payslip) R _____

Payment Details

BANKING ACCOUNT DETAILS: It is required for the direct crediting of member refunds and the direct debiting of the amounts due to the Scheme. Contributions are due monthly in advance. Claims paid by you will be credited to the banking account supplied below. For direct paying members, your account will be debited if you owe money to POLMED.

Bank Account Number _____

Name of Bank _____

Branch Number _____

Type of Account ☐ Current/Cheque Account ☐ Savings ☐ Transmission

I hereby authorise POLMED and/or its agents to credit/debit the above account as and when applicable.

Authorised Signature _____ Name _____

Details required if Applicant was a Member/Dependant of another Medical Aid

Certificates of membership of previous Scheme are required: NOTE: not membership card

Name of Applicant _____

Name of Scheme _____ Period of Membership: from _____ to _____

Name of Applicant _____

Name of Scheme _____ Period of Membership: from _____ to _____

Name of Applicant _____

Name of Scheme _____ Period of Membership: from _____ to _____

Have you ever been a member of POLMED?
If so, please state your previous membership number _____

POPI CONSENT

1. Firstly, sharing your personal health information electronically with your medical scheme and healthcare providers supports them in making better treatment decisions by having your detailed clinical history on hand. It avoids repetition of tests or treatment being prescribed when these have already been tried. Do you understand and agree to share your membership's information electronically to improve the quality of the healthcare you receive?

YES	NO

2. Your Electronic Health Record contains information about your conditions, test results and diagnoses, as well as treatment that you have received from healthcare providers. Do you understand and agree that your Electronic Health Record helps your healthcare providers to make the best treatment and healthcare decisions for you?

YES	NO

3. Your membership's healthcare providers, such as your selected doctors, specialists and pathologists, and your medical scheme will have access to your personal health information. Do you understand and agree that they will – as required by law – keep it secure and confidential?

YES	NO

4. Your medical scheme complies with national and international laws about storing and sharing your information in a safe, secure, electronic environment. Do you understand and agree that we will only provide access to authorised users? Cross-border storage is standard practice in countries with advanced standards of healthcare. This also complies with the Protection of Personal Information Act.

YES	NO

5. You can withdraw consent to share your personal healthcare information at any time. Do you understand and agree that you will be able to do this by calling the Client Service Call Centre and making this request?

YES	NO

6. If you don't agree to share your personal health information, do you understand and agree that your health information will not be shared unless you provide this consent? Your current medical benefits will however not be affected.

YES	NO

POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Membership

Consent & Declaration

My dependant(s) and I hereby give permission for the medical practitioner and/or staff member of the hospital in whose care I am/my dependant(s) are to supply:

i. Any information that POLMED and/or its agents need in order to settle any claim submitted by me or my dependant(s) to POLMED and/or its agents;
ii. POLMED and/or its agents' case manager with any information the case manager needs in order to manage my case or that of my dependant(s);
iii. The healthcare management with any information, on an anonymous and untraceable basis, that is required for administrative and statistical purposes.

It is important to give POLMED and/or its agents your consent to negotiate with your doctor(s), hospital or any other healthcare provider in order to ensure that you receive optimal care.

I declare that:

i. The content of this form is true, correct and complete;
ii. I have made my option choice on page one and that I have familiarised myself with the benefit structure under the chosen option;
iii. The mentioned particulars concerning my dependant(s) and myself are correct and I/he/she/they qualify/ies for admission as beneficiaries in terms of the rules of the Scheme;
iv. My mentioned dependant(s) are fully dependent on me.

I, and my dependant(s), shall adhere to POLMED rules. I herewith irreversibly authorise my employer to recover from my salary/bank account any amount I may legally owe POLMED and to pay over to POLMED or its agent all amounts thus recovered.

Signature _____ Date D D M M Y Y Y Y