



POLMED®

OUR INVESTMENT OUR HEALTH OUR FUTURE



AFFIDAVIT A

Sworn affidavit confirming children relationship

To whom it may concern

Submit form via

Email: polmedmembership@medscheme.co.za

Fax: 0861 888 110

Membership Number

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Persal Number

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Date

D	D	M	M	Y	Y	Y	Y
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STAMP OF COMMISSIONER OF OATHS

To be completed by the principal member of POLMED

Dear Sir/Madam

I, _____

ID Number

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hereby declare the following in respect of my dependant(s)

1. I wish to register my dependant(s) listed below as a beneficiary/ies on my POLMED membership; and
2. I also declare that my dependant(s) listed below was/were born out of wedlock and that I am the biological parent.

Details of Dependant(s) (please attach another affidavit form with dependant details completed if you have more than two dependants)

1. Dependant Full First Name _____ Dependant Surname _____

ID Number

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Relationship _____

2. Dependant Full First Name _____ Dependant Surname _____

ID Number

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Relationship _____

I thus declare on this _____ day of _____ 20_____ at _____

_____ that I know and understand the contents of this declaration. I have no objections to taking the prescribed Oath. I consider the Oath binding on my conscience. So help me God.

Principal Member of POLMED Signature _____ Date

D	D	M	M	Y	Y	Y	Y
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The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in _____ on _____ at _____ .