POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Continuation Membership

Email: polmedmembership@medscheme.co.za • Fax: 0861 888 110 • Post: Private Bag X16, Arcadia, 0007

PLEASE NOTE: It is compulsory to complete ALL sections of this form to prevent delays in processing your application. This form should be completed by pensioners or members who received a severance package, dependants of deceased members or medically boarded members.

Please supply the following documents if applicable

Orphaned children: Copy of birth certificate or a copy of ID (issued by the Department of Home Affairs) and proof of monthly income.
Children born out of wedlock: Copy of birth certificate or ID and an affidavit stating that the member is the biological parent of the child.
Dependant of deceased member: Copy of main member's death certificate and proof of income (GPAA).
Marriage: Copy of marriage certificate or customary union certificate issued by the Department of Home Affairs and copy of ID.
Dependant between 21 and 30 years who is studying: Copy of ID and a certificate of registration.
Dependant between 21 and 30 years who is financially dependent on the main member: Copy of ID and affidavit confirming financial dependency (monthly income).
Bank account details: Copy of most recent bank statement or stamped letter from bank confirming banking details.

Membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

Member Details

Surname _____

First Name (in full) _____

Initials _____ Title/Rank _____

Identity Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of Birth D D M M Y Y Y Y

Marital Status (If divorced attach a copy of final order of divorce with addendums, if any.) Gender Male Female

☐ Married ☐ Single ☐ Divorced ☐ Widow/er Date of Marriage/Divorce D D M M Y Y Y Y

Residential Address of ☐ Principal Member or ☐ Guardian (if orphaned)

_____

_____ Code _____

Postal Address of ☐ Principal Member or ☐ Guardian (if orphaned)

_____

_____ Code _____

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

Telephone (Home) _____ Telephone (Work) _____

Email _____ Fax _____

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

Membership Type

☐ Pensioner ☐ Medically Boarded ☐ Severance Package ☐ Widow/er ☐ Orphan

Date of service termination or date of death of main member D D M M Y Y Y Y

Pension Number ☐☐☐☐☐☐☐☐☐☐

POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Continuation Membership

Details of Dependant(s)

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

Surname	Full First Name	ID Number	Relationship (e.g. son/daughter)	Gender
				M F
				M F
				M F

Next of Kin's Contact 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 proof of income - GPAA) **R** _____

Payment Details

BANKING ACCOUNT DETAILS : This is required for the direct crediting of member refunds and the direct debiting of amounts due to the Scheme. Contributions are payable 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 _____

Branch Number _____

Type of Account ☐ Current/Cheque ☐ Savings ☐ Transmission

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

Authorised signature of ☐ Principal Member or ☐ Guardian (if orphaned) _____

Name _____

Chronic Medication

Do/does your dependant(s) use chronic medication? If "Yes" - please provide details: YES NO

Dependant	Illness/Condition	Period Medication Used
		From: D D M M Y Y *To:* D D M M Y Y
		From: D D M M Y Y *To:* D D M M Y Y
		From: D D M M Y Y *To:* D D M M Y Y
		From: D D M M Y Y *To:* D D M M Y Y
		From: D D M M Y Y *To:* D D M M Y Y
		From: D D M M Y Y *To:* D D M M Y Y

Pre-existing Medical Conditions

The Scheme reserves the right to impose waiting periods as defined in the rules. Should any of these apply to you, you will be notified in writing by the Scheme within one month of registration.

Medical History and General Health

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all the required information by inserting a tick in the relevant box. If the answer to any question is "YES", provide details overleaf.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. **Have you or any of your dependants ever experienced any of the following in the past 10 years?**
   - **1.1** Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)? YES NO
   - **1.2** High blood pressure or disorder/dysfunction of the blood vessels (e.g. high cholesterol, stroke or circulatory disorder/dysfunction)? YES NO
   - **1.3** Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis, persistent cough or tuberculosis)? YES NO
   - **1.4** Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)? YES NO
   - **1.5** Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)? YES NO
   - **1.6** Any nervous, mental or other neurological disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)? YES NO
   - **1.7** Any eye, ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)? YES NO
   - **1.8** Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)? YES NO
   - **1.9** Diabetes, sugar in blood or urine, thyroid, glandular or any other endocrine-related disorder/dysfunction? YES NO
   - **1.10** Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's and leukaemia), skin cancers or skin disorders/dysfunctions? YES NO
   - **1.11** Any tropical disease (e.g. bilharzia, malaria or cholera)? YES NO
   - **1.12** Any other condition, illness, disease, disorder/dysfunction, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months? YES NO
2. **Have you or any of your dependants received any surgical, medical, major dental (including implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests?** YES NO
3. **Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause?** YES NO
4. **Do you or any of your dependants currently use medication on a daily basis?** YES NO
5. **Has your weight or the weight of any of your dependants changed by more than 5 kg over the last 12 months?** YES NO
6. **Do you or any of your dependants experience any other ailment or disease at present?** YES NO
7. **Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months?** YES NO
8. **Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months?** YES NO

If you have answered "YES" to any of the preceding questions, please complete details in the following section in full:

Question number				
Name of person suffering from illness/condition				
Type of illness/condition				
Date on which illness/condition began				
Date of last occurrence				
If hospitalised, when and for how many days				
Details of operations previously performed				
Name of attending medical practitioner				

Motor Vehicle Accidents (If Applicable)

Have you or any of your dependants instituted a Road Accident Fund (RAF) claim or are you or any of your dependants planning to institute such a claim in the immediate future?

RAF Reference Number _____ Date of Accident D D M M Y Y Y Y

Name(s) of beneficiary/beneficiaries injured at the accident _____

Date(s) of consultation/treatment _____

Contact details of attorney handling the claim _____

Short description of injuries _____

Injury on Duty (IOD) (If Applicable)

Have you or any of your dependants instituted an Injury on Duty (IOD) claim or are you or any of your dependants planning to institute such a claim in the immediate future?

IOD/Compensation Commissioner's Reference Number _____ Date of Injury D D M M Y Y Y Y

Name(s) of beneficiary/beneficiaries injured on duty _____

Date(s) of consultation/treatment _____

Contact details of employer handling the claim _____

Short description of injuries _____

POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Continuation Membership

Consent and 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 dependants are to supply:

i. any information that POLMED and/or its service providers need in order to settle any claim submitted by me or my dependant(s) to POLMED and/or its service providers;
ii. POLMED and/or its service provider in the event of hospitalisation with any information the case manager needs in order to manage my case or that of my dependant(s); and
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 contracted service provider 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 am aware that as per rule 16.2.1 I can only change my benefit plan at the end of each year to take effect on 1 January of the following year;
iii. the mentioned particulars concerning my dependant(s) and me are correct and I/he/she/they qualify/ies for admission as beneficiaries in terms of the rules of the Scheme; and
iv. my mentioned dependant(s) are fully dependent on me.

I, and my dependant(s), shall adhere to the POLMED rules. I herewith irreversibly authorise POLMED to recover from my bank account any contributions I may legally owe POLMED.

Signature of ☐ Principal Member or ☐ Guardian (if orphaned) _____ Date D D M M Y Y Y Y