



Email: [polmedmembership@medscheme.co.za](mailto: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

## Change of Unit

Station \_\_\_\_\_ Unit \_\_\_\_\_

Postal Code where Station/Unit is Located \_\_\_\_\_ Effective Date

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

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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# Member Record Amendment

## 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

Reason \_\_\_\_\_

2. Surname of Dependant \_\_\_\_\_ Relationship \_\_\_\_\_

Initials \_\_\_\_\_ Title (Mr, Mrs, Miss) \_\_\_\_\_

ID Number  Effective Date

Reason \_\_\_\_\_

## Death of Member

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

Date of Death  **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

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

## Banking Account Details

Account Holder \_\_\_\_\_

Bank Account Number \_\_\_\_\_ Name of Bank \_\_\_\_\_

Branch \_\_\_\_\_ Branch Number \_\_\_\_\_

Type of Account Cheque/Current  Savings  Transmission

## 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