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 ☐☐☐☐☐☐☐☐☐☐

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

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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 ______

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