POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Chronic Medication Indemnity Form

TO BE COMPLETED IN BLOCK LETTERS AND SENT via email to **polmed@medscheme.co.za** or via fax on **0860 104 114.**
If you require assistance in completing this form, please contact the POLMED Client Service Call Centre on **0860 765 633.**

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Initials _____ Title/Rank (Mr, Mrs, Miss) _____ RSA ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

This is to certify that I, _____ Principal Member's Name and Surname

of _____ Address

do hereby confirm that I am willing to accept liability for the full payment of the extended authorisation for the period;

D D M M Y Y Y Y to D D M M Y Y Y Y i.e. _____ Duration

for _____ Name of Beneficiary (member/dependant) in Need

in the event of my ceasing to be a member of POLMED prior to the expiry of the said authorisation.

Signature of Member _____ Date D D M M Y Y Y Y

Signature of Witness _____ Date D D M M Y Y Y Y