

AFFIDAVIT B

Sworn affidavit confirming financial dependency of beneficiaries

To whom it may concern

Submit form via

Email: polmedmembership@medscheme.co.za

Fax: 0861 888 110

Membership Number

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Date:

D	D	M	M	Y	Y	Y	Y
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To be completed by the principal member of POLMED

Dear Sir/Madam

I, _____

STAMP

ID Number

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

1. I wish to register my dependant listed below as a beneficiary on my POLMED membership;
2. I declare that my dependant listed is not self-sufficient (financially and otherwise); and
3. I also declare that my dependant is (please select the option relevant to you by marking it with an "X"):

- studying (please attached proof of registration at a recognised tertiary institution)
- mentally/physically disabled (please attach a doctor's report)
- not studying anymore, but currently unemployed
- my parent and/or parent-in-law and he/she is financially dependent on me as I am responsible for him/her in terms of family care and support.

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

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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Commissioner of Oaths

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 _____

Name and Surname _____ Signature _____

Rank _____