POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Contact Details Forms
(Principal Memeber and Child Dependants)

TO BE COMPLETED IN BLOCK LETTERS AND SENT TOGETHER WITH THE ADULT DEPENDANTS CONTACT DETAILS FORM (IF APPLICABLE) TO THE MEMBERSHIP DEPARTMENT.

If you require assistance completing this form, please contact the POLMED Client Service Call Centre on **0860 765 633.**

PURPOSE OF THIS FORM
To obtain the contact details of all registered POLMED beneficiaries as per the Protection of Personal Information (POPI) Act, in order to share it with contracted third parties.

Details of Principal Member

Membership Number
Dependant Code
Rank/Title
Persal Number
Surname & Initials
ID Number
Postal Address
Code
Telephone (Work)
Telephone (Home)
Cellphone
Is your handset a smartphone? Yes No
Email Address

SAPS Unit

Head Office Division Address
Code
Station Address
Code
SAPS Cluster
Province

Details of Dependant(s) below the age of 18

Surname	Full First Name	ID Number

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Consent and Declaration

It is important to give POLMED, its Administrator, its Managed Care Organisation and its contracted service providers your consent to process, share and store your personal and medical information to ensure that you and your dependants receive optimal healthcare.

I hereby give consent for the processing and disclosing of my and my dependants' personal and medical information for the following purposes:

POLMED and its Administrator, Managed Care Organisation and third-party service providers may collect, collate, process, store (including web-based storage facilities that may be located outside the borders of South Africa) and disclose my and all my dependants' personal and medical information:

- for the administration of my or my dependants' benefits
- for providing managed care services to me or any of my dependants
- for the procurement and provision of relevant healthcare services by contracted third parties who require this information in order to provide me and my dependants with healthcare services
- for trend or risk analysis, peer review or participation in clinical studies, in which case information will be provided on an anonymous basis
- to any other contracted entity with whom I or any of my dependants already have a relationship or where I or any of my dependants have agreed to participate in a programme and/or applied for a product or benefit
- to a third party to facilitate debt collection, should any debt collection process be required due to bad debt owing to POLMED, the Administrator, Managed Care Organisation or any other healthcare providers.

Declaration

I declare that:

I. the information provided in this form is true, complete and correct.
II. I have familiarised myself with the benefit structure under my chosen option.
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.
IV. my mentioned dependant(s) are fully dependent on me.
V. I have appropriate permissions and consent from all my dependants to disclose their personal and medical information on their behalf.

I shall adhere, and I herewith undertake to ensure that my dependant(s) always adhere, to the POLMED rules. I herewith irreversibly authorise my employer to recover from my salary/bank account any amount I may legally owe POLMED and to pay over to POLMED or its agent all amounts thus recovered.

Principal Member's signature _____ Date D D M M Y Y Y Y