

Chronic Medication Indemnity

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;

to 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

Signature of Witness _____ Date