POLMED®
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APPLICATION FOR MEMBERSHIP

Who we are

The South African Police Service Medical Scheme (Polmed), registration number 374, is a restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act). It is a non-profit organisation registered with the Council for Medical Schemes. Polmed offers two excellent healthcare benefit options: **Marine and Aquarium.**

For more information on how to join Polmed, please visit **www.polmed.co.za or call 0860 765 633.**

Documentation required from main member (mandatory)

- Copy of ID
- Latest payslip and letter of appointment (not older than 3 months)
- Bank statement or stamped bank confirmation (not older than 3 months)
- Previous medical aid certificate with resignation date (if applicable)

Documentation required for each dependant

Description of dependants	Documentation required
Spouse	• A marriage certificate if married. • If in a customary marriage, a declaration from the member confirming obligation towards a spouse. • Membership certificate from a previous medical scheme (where applicable) • Copy of ID document.
Partner	• A declaration confirming that the dependant is the member's life partner. • Membership certificate from the previous medical scheme (where applicable) • Copy of ID document.
Children under the age of 21	• A declaration confirming obligation towards the child and reason for the difference in surname if the child's surname differs from the main member. • Copy of ID document or birth certificate.
Children 21 years and older	• For students: Proof of registration at a recognised tertiary institution and a declaration confirming the factual dependency of the main member. • For mental and physical disability: Proof of disability from a medical practitioner (a medical practitioner report completed by a medical practitioner) and a declaration confirming factual dependency on the main member, and that the child is not in a state institution. • If the child is not a student or disabled: A declaration confirming factual dependency on the main member. • A declaration confirming member is the child's biological parent of child and that the child is financially dependent on the member and is unemployed. • Copy of ID document.
Studying	Applications must be made every year, at the beginning of the year: • 21 up until 24 years student child rates will apply. From 25 years Adult subsidised rates will apply.
Financially dependent	• 21 up and until 29 years - Member to prove financial dependency Overage - Adult subsidised contributions rates apply. • 21 up and until 30 years - Member to prove financial dependency Overage child - unsubsidised contribution rates apply to employed dependants, learnerships and internships and earning a stipend.
Extended family (Parents, step-parents, parents-in-law, step-parents -in-law)	• A declaration confirming the factual dependency of any such dependants. • Proof of income (including income from SASSA) • Membership certificate from the previous medical scheme (where applicable) • Copy of ID document.

Declaration - A declaration MUST be an affidavit commissioned by a commissioner of oaths.

Factual dependence - A factual dependant depends on the main member for family care and support.

- A copy of each dependant's ID or birth certificate.
- Previous medical aid certificate for each dependant.
- Adult dependant rates are payable for all eligible dependants over the age of 21 to 29 years.
- Child rates are applicable to disabled dependents.
- Unsubsidised Adult contributions may be payable for offspring dependent over the age of 21 years not studying and financially dependent on the member, and students over the age of 25 years but younger than 30 years.

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FOR OFFICE USE ONLY

Membership Number

Section 1: Main Member Employment Details

Current employment

Persal, Employee or Pension Number

Current employer's name

Title/Rank

Tax Number Basic monthly salary/income (include payslip)

Previous employment

(1) Previous Employer's name

Employment start date D D M M Y Y Y Y Employment end date D D M M Y Y Y Y

Reason for termination

(2) Previous Employer's name

Employment start date D D M M Y Y Y Y Employment end date D D M M Y Y Y Y

Reason for termination

Section 2: Main Member Details

Names

Surname

Identity Number Date of birth D D M M Y Y Y Y

Height Weight

Home language

Race Gender Male Female Marital status Single Married Widow/er Divorced Co-habiting

Residential Address

Code

Postal Address

Code

Province Cluster

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Preferred method of communication.

☐ Email ☐ SMS ☐ Residential Address ☐ Postal Address

Tel (Home) Tel (Work)

Cellphone Fax

Email

Emergency Contact Person

Tel (Home) Tel (Work)

Cellphone

Email

Relationship to principal member, e.g mother/spouse

Previous medical scheme details

- Please provide proof in the form of a membership certificate.
- Please give us the details of all registered South African schemes that you previously belonged to by completing the table below and giving us the proof in the form of a membership certificate. We may use the information on the membership certificate to determine if we can apply waiting periods.

Were all your dependants on the same medical scheme YES NO

If not, please complete your dependants previous medical scheme cover details below:

Name	Scheme name	Start date	End date	If already resigned, are they still a member (yes/no)	Reason for leaving

Dependants you wish to register

Dependant 1

Name

Surname

Passport country of origin

Initials Title/Rank

Identity Number Date of birth D D M M Y Y Y Y

Cellphone Height Weight

Email address

Relationship to main member Gender Male Female

Is the dependant factually dependant on main member ☐ Yes ☐ No

Dependant type ☐ Spouse ☐ Ex-Spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older

☐ Extended family (Parents, step parents, parents in law, step parents -in-law)

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Dependant 2

Name

Surname

Passport country of origin

Initials Title/Rank

Identity Number Date of birth D D M M Y Y Y Y

Cellphone Height Weight

Email address

Relationship to the main member Gender Male Female

Is the dependant factually dependant on the main member ☐ Yes ☐ No

Dependant type ☐ Spouse ☐ Ex-Spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older
☐ Extended family (Parents, step-parents, parents-in-law, step parents-in-law)

Dependant 3

Name

Surname

Passport country of origin

Initials Title/Rank

Identity Number Date of birth D D M M Y Y Y Y

Cellphone Height Weight

Email address

Relationship to the main member Gender Male Female

Is the dependant factually dependant on the main member ☐ Yes ☐ No

Dependant type ☐ Spouse ☐ Ex-Spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older
☐ Extended family (Parents, step-parents, parents-in-law, step parents-in-law)

Refer to completing the Registering of Dependants Form for more than 3 dependants.

Section 3: Benefit Option Selection

Please select only one benefit option from the list below and mark the applicable block with an X.

☐ Marine ☐ Aquarium

- If you and your dependant(s) will be using the same nominated GP - tick box ☐
- If you have ticked the above box, you only need to complete the main member GP nomination.

Member/Dependant	Name of Polmed beneficiary	Name of GP	Practice number	Doctor's telephone number
Main member 1				
Dependant 1				
Dependant 2				
Dependant 3				

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Section 4: Your Bank Account Details

You need to complete this section in full, as we cannot register you as a member of Polmed if we do not have your bank account details. We require these details to pay any money that may be due to you, to collect your medical scheme contributions (if applicable) or recover any money that you may owe Polmed.

Name of bank

Name of account holder

Bank account no.

Branch name

Branch code

Type of account ☐ Current ☐ Savings ☐ Transmission

Debit order reference: ***Polmed Your Membership no.*** *(e.g POLMED123456789)*

I understand that the estimated monthly contributions (which are dependent on the value of any subsidy received) that I will be expected to pay if this application is accepted have also been explained to me prior to me making this application.

I hereby authorise you to issue and deliver payment instructions

☐ Monthly for collection against my bank account.

Account holder's signature

Date of signature D D M M Y Y Y Y

Section 5: Pre-existing Medical Conditions

The scheme reserves the right to impose waiting periods as defined in the rules. Should any of these apply to you, you will be notified in writing by the Scheme within one month of registration.

Medical History and General Health

To be completed by each applicant in respect of themself and all his/her dependants. Please complete all the required information by inserting a tick in the relevant box. If the answer to any question is "YES", provide details overleaf.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. Have you or any of your dependants ever experienced any of the following in the past 12 months?

1.1	Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	YES NO
1.2	High blood pressure or disorder/dysfunction of the blood vessels (e.g. high cholesterol, stroke or circulatory disorder/dysfunction)?	YES NO
1.3	Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis, persistent cough or tuberculosis)?	YES NO
1.4	Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)?	YES NO

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1.5	Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)?	YES NO
1.6	Any nervous, mental or other neurological disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)?	YES NO
1.7	Any eye, ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)?	YES NO
1.8	Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	YES NO
1.9	Any Diabetes, sugar in blood or urine, thyroid, glandular or any other endocrine-related disorder/dysfunction?	YES NO
1.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia), skin cancers or skin disorders/dysfunctions?	YES NO
1.11	Any tropical disease (e.g. bilharzia, malaria or cholera)?	YES NO
1.12	Any other condition, illness, disease, disorder/dysfunction, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months?	YES NO

2. Are you or your dependants receiving any surgical, medical, major dental (including implants), chiropractic, optical or gynaecological treatment, procedures, advice or test? YES NO

3. Do you or any of your dependants have any physical (including dental) abnormality, deformality, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? YES NO

4. Do you or any of your dependants currently use medication daily? YES NO

5. Has your weight or the weight of any of your dependants changed by more than 5kg over the last 12 months? YES NO

6. Do you or any of your dependants experience any other ailment or disease at present? YES NO

7. Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations or condition (is your dependent currently pregnant) for which you or your dependants have sought advice or received a recommendation for treatment, or received treatment during the past 12 months? YES NO

8. Are you or any of your dependants expecting to undergo any medical procedure, is your dependent currently pregnant or expecting to receive any major dental treatment during the next 12 months? YES NO

If you have answered "YES" to any of the preceding questions, please complete the details in the following section in full:
Should you require to submit more than 3 responses, kindly complete them on a separate page and attach them to this application form.

Question number	Name of person suffering from chronic illness/condition	Name of illness/ condition e.g High Blood pressure	Have you been hospitalised, when and for how many days	Date of the last occurrence of the condition e.g Epilepsy	Details of operations previously performed	Name of attending medical practictioner

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Section 6: Chronic Medication

Do/does your dependant(s) use chronic medication? If "Yes" - please provide details: YES NO

Name of person suffering from chronic illness/condition	Name of chronic illness/condition e.g High Blood pressure	Month and Year on which chronic illness/condition began	Name of chronic medication/s you are currently taking	Dosage of chronic medication and how many times a day it is taken	When did you start taking the chronic medication

Section 7: Disclosure of Personal Information

1. Sharing your personal health information electronically with Polmed, its administrators, managed care organisations and/or its agents supports them in making better treatment decisions by having your detailed clinical history on hand. It avoids repeating tests or treatments being prescribed when these have already been tried. Do you understand and agree to share your membership's information electronically to improve the healthcare quality you receive?

   YES NO

2. Polmed complies with national and international laws about storing and sharing your information in , a safe secure, electronic environment. Do you understand and agree that we will only provide access to authorised users? Cross-border storage is standard practice in countries with advanced standards of healthcare. This also complies with the Protection of Personal Information Act.

   YES NO

3. You can withdraw consent to share your personal healthcare information at any time. Do you understand and agree that you can do this by calling the Client Service Call Centre and making this request?

   YES NO

4. If you do not agree to share your personal health information, POLMED will not be shared unless you provide this consent? Your current medical benefits will however not be affected.

   YES NO

Section 8: Consent & 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 dependant(s) are to supply:

i. Any information that Polmed, its administrator/managed care organisation and/or its agents need in order to settle any claim submitted by me or my dependant(s) to Polmed, its administrator/managed care organisation and/or its agents;
ii. Polmed, its administrator/managed care organisation and/or its agents case manager with any information necessary to manage my case or that of my dependant(s);
iii. The healthcare management with any information, on an anonymous and untraceable basis, that is required for administrative, claims audit and statistical purposes.

It is important to give Polmed, its administrator/managed care organisation and/or its agents your consent to negotiate with your doctor(s), hospital or any other healthcare provider in order to ensure that you receive optimal care.

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I declare that:

i. The content of this form is true, correct and complete;
ii. I have made my option choice on page four and that I have familiarised myself with the benefit structure under the chosen option;
iii. The mentioned particulars concerning my dependant(s) and myself 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.

I, and my dependant(s), shall adhere to 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.

Signature _____ Date D D M M Y Y Y Y

Section 9: Terms and Conditions (your responsibilities)

Your application form will only be processed upon your signature appearing in this section indicating your acceptance of the terms and conditions below.

The terms and conditions contain acknowledgements of facts that may impact on your rights and that of your dependants. You therefore must read them carefully. The registered Polmed Rules, available on the Polmed' website, **www.polmed.co.za**, or by calling **0860 765 633** must be read together with these terms and conditions.

1. This application is made by myself to join Polmed and on behalf of my dependants and I confirm my authority to apply for the persons listed as dependants in this application form.
2. I understand that acceptance of my membership and dependants and to Polmed is based on my answers and supporting information supplied on this form. It will form the basis of my membership. I understand that failure to disclose any material information of both my dependants and I may result in my membership being cancelled or suspended.
3. I also understand that I must provide Polmed with all such information and evidence as it may require from time to time for purposes of my dependants and my membership of Polmed. I authorise Polmed, its administrator, its managed care organisation and/or any of its agents to obtain from any person any information which may be required concerning any of my dependants and I, and for any purpose which directly relates to our medical scheme membership or which is authorised in terms of the Act, the Rules or any other legislation. I direct that person to provide Polmed, its administrator, its managed care organisation and/or any of its agents with such information upon request.
4. I hereby declare that the dependant(s) listed on this application form is dependent on me for family care and support and are unable to support themselves financially/factually.
5. I understand that Polmed reserves the right to impose waiting periods and late joiner penalties on any beneficiary (dependants and I). Based on the information provided in this application Polmed will notify me should any of these waiting periods apply to me and/or any of my registered dependants.
6. I understand that neither my registered dependants nor I may belong to two medical schemes at the same time.
7. I undertake to notify Polmed within 30 days of any change in my circumstances or details or that of my dependants.
8. In the event of termination of membership, I acknowledge that I will be required to refund Polmed any sum of money due which has been paid by the Scheme for my dependants and I.
9. I understand the benefits of the selected option that my dependants and I will be entitled to and confirm that I have had an opportunity to consider such benefits and raise any queries pertaining thereto.
10. The total monthly contributions that I will be expected to pay have been explained to me prior to me making this application and I understand that it is my responsibility as a member to make sure that Polmed receives either my portion (where applicable) or the total monthly contribution due, failing

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Section 9: Terms and conditions (your responsibilities)

which my membership and/ or benefits may be suspended or cancelled.

11. I hereby authorise and instruct my employer to deduct from my remuneration, any such amount(s) that I may owe to Polmed from time- to-time and to pay such amounts to Polmed. Insofar as may be necessary, I hereby authorise POLMED to issue and deliver payment instructions to my bank for collection against my above-mentioned bank account.
12. I hereby consent to the recording of all conversations between myself and/or any of my dependants and Polmed, its administrator, its managed care organisation and/or any of its agents or contracted parties, and acknowledge and agree for all information obtained through these conversations to form part of the records of Polmed. I also consent that all these records remain the sole property of Polmed which records may be retained for such periods as provided for in the Rules and the relevant legislation.
13. Polmed will only pay for claims if such claims are, in Polmed' sole discretion, deemed valid and comply with the registered Polmed Rules.
14. I agree that the Scheme, its administrator and managed care organisation may process my and my 'dependants' personal information for the following purposes:
    - 14.1. to assess and process this application for membership.
    - 14.2. for the administration of my health plan.
    - 14.3. for the provision of managed care services on my chosen health plan.
    - 14.4. for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service.
    - 14.5. to profile and analyse risk.
    - 14.6. For any other lawful purpose.
15. I warrant that my dependants have permitted me to furnish all their personal information to Polmed, I confirm that I have received their permission to do so for the purposes set out herein. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and that I have such authority to give consent for them on their behalf.
16. As a member of Polmed, I authorise the Scheme to engage with my dependants and I to confirm our most recent contact details. Polmed will use this information to communicate pertinent information to my dependants and I.
17. I warrant that all and any information supplied in this application form is, to the best of my knowledge and belief, true, correct and complete.
18. I have read and I understand the Polmed Rules 16.4 governing the payment of third-party claims and undertake to reimburse or authorise the Scheme to recover all medical claims paid on my behalf where the third party liable, pays out such medical expenses incurred. In instances where the third party undertakes to pay any future medical expenses, I undertake to inform Polmed accordingly and agree that Polmed will not be liable for payment of these future medical expenses, which shall remain the responsibility of the third party.
19. I have read and understood the terms and conditions as contained herein. I acknowledge that my dependants and I shall be bound by these terms and conditions as well as by the registered Polmed Rules. My signature below binds my dependants and I to the Rules..

My signature below confirms that I give permission to the above on my dependants' and my behalf.

Signature

Date D D M M Y Y Y Y

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Submitting your completed application form

Submit your completed application form in any of the following ways:
Email: polmedmembership@medscheme.co.za
Fax: 0861 888 110
Walk-in Centres: Drop it off at any of the Polmed Walk-in-Centres nation wide.

Please ensure that you complete the form in full and attach all the supporting documents during the application period. If you do not comply with this requirement, POLMED cannot process your application, and you will have to re-apply for admission.

Use this checklist to **ensure** that you have completed all the relevant sections.

- ☐ **Section 1:** Main Member Employment Details
- ☐ **Section 2:** Main Member Details
- ☐ **Section 3:** Benefit Option Selection
- ☐ **Section 4:** Your Bank Account Details
- ☐ **Section 5:** Pre-existing Medical Conditions
- ☐ **Section 6:** Chronic Medication
- ☐ **Section 7:** Disclosure of Personal Information
- ☐ **Section 8:** Consent and Declaration
- ☐ **Section 9:** Terms and Conditions

Official use: