



Application for Registration of Dependants

Details of Dependant(s)

No person may belong to different medical schemes at the same time.

Surname	Full First Name	ID Number	Current SAPS Employee (Y/N)		Relationship (e.g. son/daughter)	Gender	
			Y	N		M	F
			Y	N		M	F
			Y	N		M	F
			Y	N		M	F
			Y	N		M	F
			Y	N		M	F
			Y	N		M	F

Nominate Your Network GP

Please complete this section below - using block letters - to nominate your network GP:

	Name & Surname	ID Number	Doctor's name	Practice number	Doctor's Email Address/ Telephone number
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

A highest ranking officer at station must complete this section.

Name

Rank

Signature:

STAMP

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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 of Dependants Added

To be completed by the principal member in respect of 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)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.2 | High blood pressure or disorder/dysfunction of the blood vessels (e.g. high cholesterol, stroke or circulatory disorder/dysfunction)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.3 | Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis, persistent cough or tuberculosis)? | <input type="checkbox"/> YES | <input type="checkbox"/> 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)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 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)? | <input type="checkbox"/> YES | <input type="checkbox"/> 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)? | <input type="checkbox"/> YES | <input type="checkbox"/> 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)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.8 | Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.9 | Diabetes, sugar in blood or urine, thyroid, glandular or any other endocrine-related disorder/dysfunction? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.10 | Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia), skin cancers or skin disorders/dysfunctions? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.11 | Any tropical disease (e.g. bilharzia, malaria or cholera)? | <input type="checkbox"/> YES | <input type="checkbox"/> 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 1.13 | Been tested for, received or expect to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS, an AIDS-related condition or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea or syphilis)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. | Have or are you or any of your dependants receiving any surgical, medical, major dental (including implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. | Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. | Do you or any of your dependants currently use medication on a daily basis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. | Has your weight or the weight of any of your dependants changed by more than 5 kg over the last 12 months? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. | Do you or any of your dependants experience any other ailment or disease at present? | <input type="checkbox"/> YES | <input type="checkbox"/> 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 other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. | Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |



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Medical History and General Health of Dependants Added (CONTINUED)

If you have answered "YES" to any of the preceding questions, please complete details in the following section in full:

Question number				
Name of person suffering from the illness / condition				
Type of illness/condition				
Date on which illness/condition began				
Date of last occurrence				
If hospitalised, when and for how many days				
Details of operations previously performed				
Name of attending medical practitioner				

Chronic Medication

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

Dependant	Illness/Condition	Period Medication Used													
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y
		From:	D	D	M	M	Y	Y	To:	D	D	M	M	Y	Y

Advice of Change in Marital Status (If Applicable)

- Please terminate my membership, as I will be registered as a dependant on my spouse's medical scheme.
- Please change my marital status to the following: Married Divorced Widowed

Details Required if Applicant was a Member/Dependant of Another Medical Scheme

Certificates of membership of previous medical schemes are required. Note: Not a membership card.

Name of Applicant _____

Name of Medical Scheme _____ Period of Membership: from _____ to _____

Name of Applicant _____

Name of Medical Scheme _____ Period of Membership: from _____ to _____

Name of Applicant _____

Name of Medical Scheme _____ Period of Membership: from _____ to _____

Name of Applicant _____

Name of Medical Scheme _____ Period of Membership: from _____ to _____

Have you ever been a member of POLMED? If so, please state your previous membership number _____

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POPI CONSENT

1. Firstly, sharing your personal health information electronically with your medical scheme and healthcare providers supports them in making better treatment decisions by having your detailed clinical history on hand. It avoids repetition of tests or treatment being prescribed when these have already been tried. Do you understand and agree to share your membership's information electronically to improve the quality of the healthcare you receive?
2. Your medical scheme 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.
3. You can withdraw consent to share your personal healthcare information at any time. Do you understand and agree that you will be able to do this by calling the Client Service Call Centre and making this request?
4. If you don't agree to share your personal health information, do you understand and agree that your health information will not be shared unless you provide this consent? Your current medical benefits will however not be affected.

Consent and 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 dependants are to supply:

- i. any information that POLMED and/or its service providers need in order to settle any claim submitted by me or my dependant(s) to POLMED and/or its service providers;
- ii. POLMED and/or its service provider in the event of hospitalisation with any information the case manager needs in order to manage my case or that of my dependant(s); and
- iii. the healthcare management with any information, on an anonymous and untraceable basis, that is required for administrative and statistical purposes.

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

I declare that:

- i. the content of this form is true, correct and complete;
- ii. I am aware that as per rule 16.2.1 I can only change my benefit plan at the end of each year to take effect on 1 January of the following year;
- 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; and
- iv. my mentioned dependant(s) are fully dependent on me.

I, and my dependant(s), shall adhere to the POLMED rules. I herewith irreversibly authorise POLMED to recover from my bank account any contributions I may legally owe POLMED.

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Consent and Declaration (CONTINUED)

Signatures of all dependants who are over 14 years old

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Dependant _____ Initials and Surname _____

Date

Signature of Principal Member _____ Date _____