Adult Dependant Contact Details Form

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TO BE COMPLETED IN BLOCK LETTERS AND SEND 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 adult 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
Occupation
Code
Telephone (Work)
Telephone (Home)
Cellphone
Is your handset a smartphone? Yes No
Email Address

Details of Dependant(s) over the age of 18

Dependant 1

Name
Surname
Postal Address
Title
Occupation
Identity Number
Cellphone
Tel Number (w)
Tel Number (H)
Email Address

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Dependant 2

Name
Surname
Postal Address
Title
Occupation
Identity Number
Cellphone
Tel Number (w)
Tel Number (H)
Email Address

Dependant 3

Name
Surname
Postal Address
Title
Occupation
Identity Number
Cellphone
Tel Number (w)
Tel Number (H)
Email Address

Dependant 4

Name
Surname
Postal Address
Title
Occupation
Identity Number
Cellphone
Tel Number (w)
Tel Number (H)
Email Address

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:

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Consent and Declaration *(Continued)*

POLMED and its Administrator, Managed Care Organisation and third-party service providers may collect, collate, process, store (include 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 memtioned particulars concerning my dependant(s) and me are correct and I/he/she/they qualify/ies for admission as beneficiaries interms 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 discole their personal 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 nay 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