Application for Continuation Membership

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OUR INVESTMENT OUR HEALTH OUR FUTURE

Email: polmedmembership@medscheme.co.za
PLEASE NOTE: It is compulsory to complete ALL sections of this form to prevent delays in processing your application. This form should be completed by pensioners or members who received a severance package, dependants of deceased members or medically boarded members.
Please supply the following documents if applicable:

- Member: Copy of ID, Proof of income, letter form Medical Board (Ill Health) and Service certificate.
- Orphaned children: copy of the birth certificate or a copy of ID (issued by the Department of Home Affairs and proof of monthly income).
- Children born out of wedlock: copy of the birth certificate or a copy of ID and an affidavit stating that the member is the biological parent of the child.
- Dependant of deceased member: copy of main member's death certificate and proof of income (GPAA).
- Marriage: copy of marriage certificate or customer union certificate issued by the Department of Home Affairs and copy of ID.
- Dependant between 21 and 25 years who is studying: copy of ID and a certificate of registration.
- Dependant over the age of 21 who is financially dependent on the member: copy of ID and affidavit confirming financial dependency and monthly income.
- Bank account details: copy of most recent bank statement or stamped letter from bank confirming banking details.

Membership Number ☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

Member Details

Surname _____

First Names (in full) _____

Initials _____ Title/Rank _____

Identity Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

Marital status (If divorced attach a copy of final order of divorce with the addendums, if any)

Gender Male Female

☐ Married ☐ Single ☐ Widow/er Date of marriage/divorce D D M M Y Y Y Y

Residential Address of ☐ Principal Member or ☐ Guardian (if orphaned)

_____

_____ Code _____

Postal Address ☐ Principal Member or ☐ Guardian (if orphaned)

_____

_____ Code _____

Please indicate how you wish to receive your correspondence ☐ Email ☐ SMS ☐ Residential Address ☐ Postal Address

Tel (Home) _____ Tel (Work) _____

Email _____ Fax _____

Cellphone _____ Is your cellphone web-enabled (WAP) ☐ Yes ☐ No

Membership Type

☐ Pensioner ☐ Medically Boarded ☐ Severance Package ☐ Widow/er ☐ Orphan

Date of service termination or date of main member ☐☐☐☐☐☐☐☐

Pension Number ☐☐☐☐☐☐☐☐☐☐

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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	
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐

Next of Kin's Details

Surname and initials _____

Postal Address _____

_____ Code _____

Cellphone _____

Email _____

Relationship to principal member, e.g. mother/spouse _____

Income Category

Please indicate your basic monthly salary/income (include payslip) R _____

Payment Details

BANKING ACCOUNT DETAILS: It is required for the direct crediting of member refunds and the direct debiting of the amounts due to the Scheme. Contributions are due monthly in advance. Claims paid by you will be credited to the banking account supplied below. For direct paying members, your account will be debited if you owe contributions and claims to POLMED.

Bank Account Number _____

Name of Bank _____

Branch Number _____

Type of Account ☐ Current/Cheque Account ☐ Savings ☐ Transmission

Please choose debit order date suitable for you 25th | 27th | 1st

I hereby authorise POLMED and/or its agents to credit/debit the above account as and when applicable.

Authorised Signature ☐ Principal member or

☐ Guardian (if orphaned) or _____

☐ Third Party Payer

Name _____

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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

To be completed by each applicant in respect of himself/herself 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
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 lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia), skin cancers or skin disorders/dysfunctions?	YES	NO
1.10	Any tropical disease (e.g. bilharzia, malaria or cholera)?	YES	NO
1.11	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 (include 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 on a daily basis?	YES	NO

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Medical History and General Health (Continued)

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 advice has been sought or treatment has been received or recommended 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 details in the following section in full:
Should you require more than 3 responses kindly complete on a seperate page and attach to this application form.

Question	Question number	Question number	Question number
Name of person suffering from 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 practictioner			

Motor Vehicle Accidents (If Applicable)

Have you or any of your dependants institute a Road Accident Fund (RAF) claim or are you or any of your dependants planning to instituted a such a claim in the immedaite future?

RAF Reference Number _____ Date of Accident D D M M Y Y Y Y

Name(s) of beneficiary/beneficiaries injured at the accident _____

Date(s) of consultation/treatment _____

Contact details of Attorney handling the claim _____

Short description of injuries _____

Relationship to principal member, e.g. mother/spouse _____

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Injury on Duty (IOD) (If Applicable)

Have you or any of your dependants instituted an Injury on Duty (IOD) claim or are you or any of your dependants planning to institute such a claim in the immediate claim?

IOD/Compensation Commissioner's Reference number _____ Date of injury D D M M Y Y Y

Name(s) of beneficiary/beneficiaries injured on duty _____

Date(s) of consultation/treatment _____

Contact details of Employer handling the claim _____

Short description of injuries _____

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?

YES	NO

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.

YES	NO

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?

YES	NO

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.

YES	NO

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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 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);
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 POLMED rules. I herewith irreversibly authorise POLMED to recover from my bank account any contributions I may legally owe POLMED.

Signature of ☐ Principal member or ☐ Guardian (if orphaned) _____

Date D D M M Y Y Y Y