Application for Registration of Dependants

POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Email: polmedmembership@medscheme.co.za • Fax: 0861 888 110

PLEASE NOTE: It is compulsory to complete ALL sections of the application form to prevent delays in processing your application.

Member Details

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

First Names (in full) _____

Surname _____

Name of Police Station where the member is stationed _____

City and Province _____

Telephone Number (W) ☐☐☐☐☐☐☐☐☐☐ Cellphone Number ☐☐☐☐☐☐☐☐☐☐

Registration of New Dependants

Dependants	Documents Required
Biological child **Child/children born before or out of wedlock**	• Copy of birth certificate • Affidavit confirming member is the biological parent of child
Legally adopted child/children	• Copy of birth certificate • Final adoption order
Stepchild	• Copy of birth certificate • Affidavit from member confirming that the child is the biological child of the member's spouse • Copy of marriage certificate/lobola letter/affidavit confirming co-habitation and financial dependency for partner
Dependant over the age of 21 years • A dependant shall qualify for membership if he/she is studying at a registered learning institution, unmarried, unemployed and not a member of another medical scheme or is financially dependent on the member. • Child contribution rates will apply to students between 21 and 24 years. • Adult subsidised contributions will apply to dependants over 21 years, not studying and financially dependent on the member, and students 25 years and older. • **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 adult subsidised rates will apply. • **Financially dependent:** - 21 up and until 29 years - Member to prove financial dependency for overage child - adult subsidised contributions rates apply.	• Copy of ID • Certificate of registration • Affidavit confirming financial dependency • A declaration confirming member is the biological parent of child and that the child is financially dependent on the member and is unemployed
Husband/wife • The lawful spouse may be registered as a dependant. • The spouse's membership is terminated on the date of divorce or on the date of cancellation as a dependant as advised by the member in writing. • Full contributions without subsidy from the employer will apply (for ex-spouse). • According to customary law, a member is permitted to have more than one wife and he may register additional wives as dependants.	• Copy of ID • Copy of marriage certificate or customary union certificate • Membership certificate from previous medical scheme if applicable
Member's partner • Where a member and partner (whether heterosexual or not) have lived together before applying for membership and the member and partner are financially dependent on one another, the partner may register as a dependant.	• Copy of ID • Three affidavits – one from the member, a partner and a witness – confirming co-habitation and financial dependency on main member • Membership certificate from previous medical scheme if applicable
Disabled child/children • A disabled child, including stepchild, adopted child or foster child over the age of 21 years, who is financially dependent on the principal member, may be registered as a dependant. • The principal member must annually furnish proof of the disability by means of an updated medical report.	• Copy of ID • Copy of birth certificate • Annual proof of disability supplied by medical practitioner

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Registration of New Dependants (CONTINUED)

Dependants	Documents Required
Biological parents/parents-in-law/step parents/step parents-in-law • A member may register his/her biological parents/parents-in-law/step parents/step parents-in-law as dependants if they are financially dependent on the member. • Proof of dependency must be supplied. • Full contributions without the subsidy from the employer will apply. • Application must be made every year on the anniversary month (month the dependant joined POLMED).	• Copy of ID • Proof of monthly income • Affidavit confirming financial dependency • Membership certificate of previous medical scheme if applicable

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

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					

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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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)?	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	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
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)?	YES 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? YES 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? YES NO

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

5. Has your weight or the weight of any of your dependants changed by more than 5 kg 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 other conditions (including pregnancy) 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, operation, confinement or receive any major dental treatment during the next 12 months? YES NO

Application for Registration of Dependants

POLMED
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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				

Disclosure of Health Conditions Impacting Functionality / Disability Disclosure

Details of person(s) living with a disability

First name/s

Initial(s) Surname

Date of birth D D M M Y Y Y Y ID number

Passport number, if no ID

Description of disability

Disability Type
(Please tick the applicable box)

☐ Hearing Disability ☐ Intellectual Disability ☐ Mental Disability
☐ Physical Disability ☐ Speech Disability ☐ Vision Disability

Nature of Disability
(Please tick the applicable box)

☐ Temporary ☐ Permanent

Limitation
(Please tick the applicable box)

☐ Mild ☐ Moderation ☐ Severe

Start Date* D D M M Y Y Y Y End Date D D M M Y Y Y Y

** Compulsory field, Onset of the Disability.*

Treating Provider Details

Practice number Initial(s)

Name/s

Surname

Cellphone Telephone

Practitioner Email

Should this space be insufficient, please attach a separate sheet.

Application for Registration of Dependants

POLMED
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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)

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

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 and Declaration

My dependant and I hereby permit the medical practitioner/ hospital in whose care I am to supply information that POLMED and its service providers need to:

Assess the risk to be covered by the medical scheme (s32(1)(b)(i) of POPIA). Perform the business of the medical scheme in terms of the registered rules, including managing cases in the event of hospitalisation or settling claims submitted to POLMED (s32(1)(b)(ii)). Enforce contractual rights and obligations as per the scheme registered rules (s32(1)(b)(iii)). Supplement the processing of personal information regarding data subject health (s32(4)). Statistical purposes (s27(1)(d), 35(1)(d)).

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.

Signatures of all dependants who are over 14 years old

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Dependant _____ Initials and Surname _____

Date D D M M Y Y Y Y

Signature of Principal Member _____ Date _____

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A highest ranking officer at station must complete this section.

Name

Rank

Signature:

STAMP