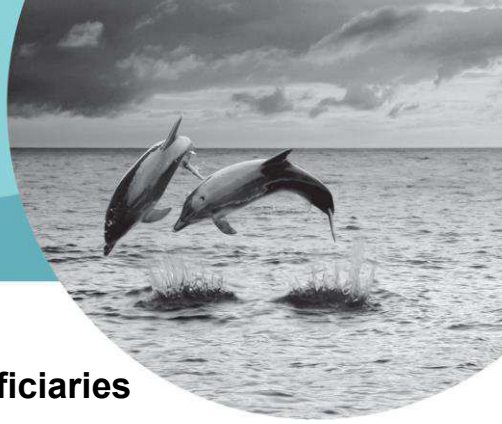
POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE



AFFIDAVIT B
Sworn affidavit confirming financial dependency of beneficiaries

To whom it may concern

Submit form via
Email: polmedmembership@medscheme.co.za
Fax: 0861 888 110

STAMP OF COMMISSIONER OF OATHS

Membership Number

Persal Number

Date
D D M M Y Y Y Y

To be completed by the principal member of POLMED

Dear Sir/Madam

I, _____

ID Number

hereby declare the following in respect of my dependant

1. I wish to register my dependant listed below as a beneficiary on my POLMED membership;
2. I declare that my dependant listed is not self-sufficient (financially and otherwise); and
3. I also declare that my dependant is (please select the option relevant to you by marking it with an "X"):

- studying (please attached proof of registration at a recognised tertiary institution) ☐
- mentally/physically disabled (please attach a doctor's report) ☐
- not studying anymore, but currently unemployed ☐
- my parent and/or parent-in-law and he/she is financially dependent on me as I am responsible for him/her in terms of family care and support. ☐

Details of Dependant (please attach a separate sheet if you have more than one dependant)

Dependant Full First Name _____ Dependant Surname _____

ID Number

Relationship _____

I thus declare on this _____ day of _____ 20_____ at

_____ that I know and understand the contents of this declaration. I have no objections to taking the prescribed Oath. I consider the Oath binding on my conscience. So help me God.

Principal Member of POLMED Signature _____ Date D D M M Y Y Y Y

The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in_____

on _____ at _____ .