KeyHealth MEDICAL SCHEME

# SWORN AFFIDAVIT
## CONFIRMING FINANCIAL DEPENDENCY OF BENEFICIARIES

## Instructions:

Complete the affidavit then **sign it in the presence of a licensed witness or notary**.
Submit it via e-mail to **membership@keyhealthmedical.co.za** or fax it to **0860111390**

**To whom it may Concern**

Membership Number:

Date
D D – M M – 2 0 Y Y

## To be completed by the principal member of KEYHEALTH

Dear Sir/Madam

I, _____

ID number Y Y M M D D

hereby declare the following in respect of my dependent (please select the option relevant to you by marking it with an "X")

1. I declare that my dependant listed is not self-sufficient (financially and otherwise); ☐ and

2. I also declare that my dependant is:

| | |
|---|---|
| Studying *(please attach proof of registration at a recognised tertiary institution)* | ☐ |
| Mentally/physically disabled *(please attach a report from a doctor and/or a occupational therapist)* | ☐ |

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

| | |
|---|---|
| Dependant full first name | |
| Surname | |
| ID number | Y Y M M D D |
| Relationship | |

I 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 also understand that it is my responsibility to inform KeyHealth if the self-sufficiency (financially and otherwise) of the above listed dependant changes.

Principal Member of KEYHEALTH Signature _____ Date D D – M M – 2 0 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 before

me _____

on this _____ day of _____

20 _____ at _____

STAMP OF COMMISSIONER OF OATHS