

# INDIVIDUAL MEMBER BENEFIT OPTION CHANGE FORM



## 1. APPLICANT (PRINCIPAL MEMBER)

Membership number	<input type="text"/>
Surname	<input type="text"/>
Initials	<input type="text"/>
ID number	<input type="text"/>

## 2. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address	<input type="text"/>
Telephone number (w)	<input type="text"/>
Cellphone number	<input type="text"/>
Postal address	<input type="text"/>
Code	<input type="text"/>

## 3. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	<input type="checkbox"/>
Beat2	<input type="checkbox"/>
Beat3	<input type="checkbox"/>
Beat4	<input type="checkbox"/>

Beat1N (Network) †	<input type="checkbox"/>
Beat2N (Network) †	<input type="checkbox"/>
Beat3N (Network) †	<input type="checkbox"/>

Pace1	<input type="checkbox"/>
Pace2	<input type="checkbox"/>
Pace3	<input type="checkbox"/>
Pace4	<input type="checkbox"/>

Pulse1 * ‡	<input type="checkbox"/>
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Income bracket if you are joining on the Pulse1 Option:

R 0 - R 5 500 monthly	R 5 501 - R 8 500 monthly	R 8 501 and above monthly
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\* Provide **proof of income** (3 months' payslips or bank statements - not older than 3 months). Please note that you will be registered on the highest interval, pending proof of income.

† **Take note: Members on any of the BeatN options enjoy an efficiency discount. As such, please note that by selecting one of the BeatN options you acknowledge and agree to the following conditions:**

1. I am limited to a hospital network and designated service providers as determined by the Scheme.
2. I am aware of the location of the nearest above-mentioned network hospital providers.
3. If I willingly do not make use of the aforesaid network providers, I am aware, and agree that I will be held liable for a co-payment in terms of the Scheme Rules.
4. I am aware that this is a unique benefit option and that I may not, in terms of the Scheme Rules, change from a BeatN option to a standard Beat option during the year.

‡ **Take note: Members on the Pulse option are restricted to the contracted Pulse designated service provider network. As such, by selecting the Pulse option, you acknowledge and agree that your option is subject to the following:**

1. Primary care service provider network
2. Specialist network
3. Hospital network

## 4. STATEMENT BY MEMBER

I																											
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1. I hereby expressly make the following acknowledgements in respect of Bestmed's processing of my Personal Information and/or Special Personal Information and/or that of my dependants/child(ren)/spouse(s) ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):
  - 1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy, thereby fully appreciating the manner in which Bestmed may process my Personal Information and for which purpose(s) Bestmed may process such Personal Information.
  - 1.2 That through submitting this application, I may be providing Bestmed with the Personal Information of my spouse(s), children and/or other dependant third parties.
  - 1.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by me from time to time.
  - 1.4 That Bestmed may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.
  - 1.5 That I fully appreciate that Bestmed places a high premium on my privacy and/or that of my dependants, spouse(s) and/or children.
  - 1.6 That I have read and understood the undertakings made by Bestmed in its Data Protection and Privacy Policy to the effect that it will ensure that any and all of my Personal Information and/or that of my dependants/child(ren)/spouse(s) shall be processed with a reasonable standard of care as may be expected from Bestmed.
  - 1.7 That I fully appreciate that Bestmed will only process my Personal Information and/or that of my dependants/child(ren)/spouse(s) in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
  - 1.8 That, in accordance with the provisions of Section 18 of POPIA, I have been provided with adequate notification of the processing of my Personal Information by Bestmed, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so.
  - 1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.
  
2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants/child(ren)/spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
  - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.
  - 2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
  - 2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.
  - 2.4 To administer my claims and premiums.
  - 2.5 To activate my medical aid and/or prescribed benefits.
  - 2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.
  - 2.7 For general administration purposes pertaining to my membership.
  - 2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.
  - 2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.
  - 2.10 To provide me with health and wellness information throughout the subsistence of my membership.
  - 2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.
  - 2.12 To analyse my Personal Information collected for research and statistical purposes.
  - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
  - 2.14 To carry out analysis and profiling of my membership profile.
  
3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No
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Signature of member

## 5. APPLICATION AND DECLARATION

Please note that option changes may only be made effective from 1 January of a financial year, provided that the request is received before 31 December. I understand the benefits of my new option choice and accept the option change on my membership profile.

Signed by me 



 on this 







 day of 



 month

Signature of principal member

\* The rules of the Scheme will determine admission and the applicable rates.