CONSENT FOR THE SHARING OF PERSONAL/SPECIAL PERSONAL INFORMATION



As defined in the Protection of Personal Information Act, 4 of 2013

By completing sections 1 or 2 of this form, you allow Bestmed Medical Scheme to share the specified Personal/Special Personal Information with the nominated party(ies) indicated in the applicable sections of the form.

Examples of the information that will be available to the nominated party

Biographical information	Benefit information	Financial information	Medical information
 Membership number Date of birth ID number Postal address Residential address Email address Contact numbers 	Benefit option Available medical savings account balance Available benefits Limits on benefit option Waiting period information	 Monthly subscription Tax certificate Membership certificate Balance due or outstanding 	Chronic or prescribed minimum benefit conditions details Status of authorisations Claim transaction history Medication used Medical procedures performed as well as procedure codes

- Contact number	C13																						
1. CONSENT BY	THE M	EMBE	R (II	ISTR	UCT	OR)																	
By completing this se listed in the examples		orovide o	onsent	to the	nomin	ated pa	arty, i.e	. mem	ber or o	depend	ant, to	have a	ccess t	o acce	ss youi	Perso	nal/Sp	ecial P	ersona	l Infor	mation	, as	
I, Title				Initials					Membership number														
Full name																							
Surname																							
ID/Passport number																							
Country of issue																							
Email address																							
Cellphone number																							
hereby nominate:																							
1. Consent by the me as listed in the examp		estmed	registe	ered bei	neficia	ry (i.e. ı	membe	er or de	penda	nt) with	whom	we m	ay sha	re the s	specifie	ed Pers	onal/S	pecial	Person	al Info	rmatio	n,	
Membership number										Beneficiary number													
Name																							
Surname																							
Relationship to member													Dat birt		D	D	M	M	Υ	Υ	Υ	Υ	
ID/Passport number																							
Country of issue																							
Email address																							

Cellphone number

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2. Consent by member to a nominated third party or next of kin. By completing this section, you, the member provide permission to the nominated third party or next of kin (not registered under the Bestmed profile) to access the specified Personal/Special Personal Information, as listed above, of all registered beneficiaries. Relationship														kin									
Relationship to member																							
Name																							
Surname																							
ID/Passport number																							
Country of issue																							
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Cellphone number]			ate of		D	D	M	М	Υ	Υ	Υ	Υ
2. CONSENT BY	CONSENT BY A REGISTERED DEPENDANT (INSTRUCTOR)																						
1. By completing this section, you as the dependant, who is 18 years or older, provide permission to the registered beneficiary (i.e. member or dependant) to access your																							
Specified Personal/Special Personal Information, as listed in the examples above.																							
Fill out the detail of the dependant who gives the consent here. I,																							
" Membership numbe																							
Name																	1						
Surname																							
Relationship to														Dat birt		D	D	M	M	Y	Υ	Y	Y
member ID/Passport number															11								
Country of issue																							
Email address																							
Cellphone number											 												
hereby nominate an	d appoi	nt:									J												
2. Fill out the detail			to wh	om the	conse	nt is gi	ven to a	access	the sp	ecified	Person	nal/Spe	cial Pe	ersona	Inforn	nation,	as list	ed in th	ne exar	nples a	bove.		
Membership numbe	r										Be	neficia	y num	ber									
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Surname																							
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3. TERMS AND CONDITIONS ON THE CONSENT

to be completed by the instructor and the nominated party

- 1. I hereby give informed consent for Bestmed to share my Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013 ("POPIA") with the duly nominated party(ies).
- 2. I acknowledge that my Personal/Special Personal Information includes, but is not limited to my health, medical and treatment records.
- 3. I confirm that I understand that the Personal/Special Personal Information that may either be obtained from or disclosed to the duly nominated party(ies) may include the Personal/Special Personal Information of my dependants in the case of the member.
- 4. I agree that Bestmed will not be held liable for any loss, including direct, indirect, and consequential loss, or claims resulting from the wrongful or unauthorised use of shared Personal/Special Personal Information, that may arise from any disclosure contemplated herein.
- 5. I am aware that Bestmed subcontracts certain services to third parties and, as a result, I indemnify any subcontracted service provider of any liability relating to privacy where the sharing of information relates to the provision of healthcare services in terms of the Medical Schemes Act.
- 6. I agree that once consent is provided, all data listed in the examples above will be provided to the duly nominated party(ies).
- 7. This consent will be in force until expressly withdrawn in writing by the instructor.
- 8. This consent will become null and void in the event of the death of a member or dependant providing consent and a new consent form shall be completed by the executor appointed.
- 9. Bestmed will only share the information with the duly nominated party(ies) and will not accept any instructions with regard to changes and/or updates to the profile from any of the nominated parties.

Name of instructor																			
Signature of instructor						_			D			D		D.4	N/1	Y	Υ	Y	Y
8									Di	ate		D	D	M	M	Y	Y	Y	Y
1. Name of					\top														
nominated party																			
1. Signature of nominated	party							Date				D	D	M	М	Υ	Υ	Υ	Υ
2. Name of		1		<u> </u>		1													
nominated party																			
2. Signature of nominated	party					_			Da	ate		D	D	M	М	Υ	Υ	Υ	Υ