## **MEMBERSHIP CONTINUATION FORM**



1. REASON FOR CHANGE																							
Chang	e due to co	ntinuatio	n ac a n	oncion	or							Char	ige effe	octivo f	rom	D	D	М	М	Y	Y	Υ	Υ
Change due to continuation as a pensioner										Criai	ige eine	ctive i	10111			141	1 1 1	'	<u>'</u>		'		
Change from individual to corporate membership											Char	ige effe	ective f	rom	D	D	M	М	Υ	Υ	Υ	Υ	
Chang	e from corp	orate to	individu	ıal men	nbersh	ip						Char	ige effe	ective f	rom	D	D	M	М	Υ	Υ	Υ	Υ
2. DETAILS	2. DETAILS OF PRINCIPAL MEMBER																						
Title				]	ı	Full na	mes																
Surname																							
ID number													Date	of birt	:h	D	D	М	М	Υ	Υ	Υ	Υ
Home language																							
Passport numb	er																						
Country of issu	e (passport)	)																					
SARS tax numb	er (SARS le	gislative	require	ment)																			
Tel number											С	ell num	ber										
Physical address																							
																		C	ode				<u> </u>
Email address																							

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## 3. BENEFIT OPTION

Option change subje New benefit option (ind				nd rel	evant	appro	val. P	lease	refer	to Bes	tmed	Scher	ne Ru	les									
Beat1					Beat1N	(Netw	ork) †				Р	ace1						Rh	ythm1	* ‡			
Beat2					Beat2N	(Netw	ork) †				Р	ace2						Rh	ythm2	* ‡			
Beat3					Beat3N	l (Netw	ork) †				Р	ace3											
Beat3 Plus											P	ace4											
Beat4																							
Income bracket if you a	re joinii	ng on	the R	hythm	11 Opti	on			Inc	ome bi	racket	if you a	are join	ing on	the Rh	ythm2	Option	n					
R 0 - R 9 000 monthly	R 9		R 14 nthly	000	R 14 001 and above monthly				R 0 - R 5 500 R 5 501 - R 8 500 monthly monthly						a	R 8 501 and above monthly							
* Provide <b>proof of incom</b> Please note that you w											ns).												
Members on any of th	e Beatl	N opti	ions e	njoy a	n effici	ency d	iscoun	t. By s	electing	g one o	f the E	eatN o	ptions	, you a	cknow	ledge a	nd agr	ee to t	he follo	owing	conditi	ons:	
1. I am limited to a hos	spital ne	etwor	k and	design	ated se	ervice p	rovide	rs as d	etermir	ned by	the Scl	neme.											
2. I am aware of the lo	cation o	of the	neare	st abo	ve-me	ntioned	l netwo	ork hos	pital pr	ovider	S.												
3. If I willingly do not n	nake us	e of tl	he afo	resaid	netwo	rk prov	iders, I	am aw	are an	d agree	that I	will be	held lia	able for	а со-р	aymen	t in ter	ms of t	the Sch	eme R	ules.		
4. I am aware that this	is a un	ique b	enefit	optio	n and t	hat I m	ay not,	in terr	ns of th	e Sche	me Ru	les, cha	ange fr	om a B	eatN o	ption to	a star	ndard E	Beat op	tion du	iring th	e year.	
Members on a Rhythn that your option is sul					the co	ntract	ed Rhy	thm d	esignat	ed ser	vice pr	ovider	netwo	rk. By	selecti	ng a Rh	ythm o	ption,	you ac	:knowl	edge a	nd agre	:e
1. GP network																							
2. Specialist network (I	Referra	l requ	ired fr	om ne	twork (	GP)																	
3. Hospital network																							
. YOUR BANKING	DET	AILS																					
<b>DEBIT ORDER FOR MON</b> For monthly contributions								anking	details l	pelow.													
* Debit order deduction	date		2	20 <sup>th</sup>		25 <sup>th</sup>		1 <sup>s</sup>	t														
Bank																							
Branch																							
Branch code								Туре	of accou	ınt	C	heque	/ curre	nt		Savi	ngs						-
Account number																							
Select account holder		Mem	ber			Comp	any*			Othe	r*						1						
*If you have selected "COM COMPANY	/IPANY"	or "0	THER"	please	comple	ete the s	ections	below	, includi	ng the a	addres	section	n. This is	s in acco	ordance	with S	ARS leg	islative	require	ments.			
Registered name of comp	any																						
Type of company (e.g. priv	rate)																						
Entity registration numbe	r																						
OTHER					1	1	<u> </u>	1	1	<u> </u>	1	1	1	1	1	1		1		<u> </u>	1	<u> </u>	
Title																							

First name

Middle name

Surname

Acc	Account holder ID number																							
Pas	ssport number (for n	on-SA	citizens	)																				
Cou	untry of issue																							
SAI	RS tax number (mand	latory)											Da	ite of bi	irth		D	D	М	М	Υ	Υ	Υ	Υ
	ysical address																							
	MPANY" and "OTHER")																							
																Postal	code							
Are	AIMS REFUND BAN your claims refund l ou selected "NO", pl	banking	g details	the sa							details	?										Yes		Vo
Bar	nk																							
Bra	anch																							
Bra	anch code								Туре о	f accou	nt		Che	eque / (	current				Sa	vings				
Acc	count number																							
Na	me of the account ho	older																						
If a	If account holder differs from principal member, please confirm account holder ID number/passport number for non-SA citizens																							
Acc	count holder ID numb	oer																						
cor as we reg for we thir	ve hereby authorise ntribution amount for contributions are are are agree to pay bank or gistered post, starting payments incurred are legally owing to lard party without my itten consent of the opject to subscription	or the s mended charges ng on the . I/we u Bestme i/our proper	selected d from s s relatin he first underst ed. I/we rior writ rised pa	d benefitime to ng to the day of and the acknown acten co	fit option time. It is debit the following at I/we owledge insent and the deduction of the first the first tent and the deduction of the deduction of the first tent and the deduction of the first tent and the deduction of the deduction of the first tent and the deduction of the first tent and the	on on the such all such it order lowing shall returned that the sand that the son on the sand	he about the head of the head	ve-mer Irawals ction. T lar mor entitled ty here may no	ntioned from r his aut hth. Sho I to any by auth ot deleg	date on ny/our hority buld the refund norised gate ar	or the fi accour may be ere be a ds of ar to effe ay of my	rst won t by Be cance a breac mounts ect the y/our o	king da estmed led by h of thi which drawin bligatio	ay ther I shall to me/us is conto have to g(s) agons in t	eafter. De treat by givi ract the Deen wi ainst m	I/we fu ted as t ng Bes ere is a thdraw ny/our a f this co	rther a hough tmed o possibi n while account	uthoristhey had ne modelity that this a this a thus recorded to the may recorded to the theory of the theory recorded to the theory recor	se Best ave beanth's nat the nat the national authority to control to the control	en sign otice in nembe cy was e or as o any th	adjus ed by r writin r will b in force sign an	t the ar ne/us p g via er e held r e if such y of its ty with	mount opersonation for the series of the ser	due ally. I/ x or sible nts to any
Signa	ture of principal me	mber											Signa	ture of	accour	nt holde	er							
5. B	ROKER CONF	IRM/	ATIO	N																				
	BROKER CONFIRMATION  Change subject to the broker appointment contract with the employer group  In terms of the Financial Accounting Information System (FAIS) Act, please select the appropriate option																							
	I want to con	tinue w	ith my	curren	t broke	rage / I	broker.																	
	I want to appoint a new brokerage / broker on my Bestmed membership profile. Please complete section 7 of the Bestmed continuation form.																							
	I want to remove my current broker. I will deal with Bestmed in my own capacity.																							

5. NEW BRO	KER	DETA	ILS																					
Brokerage name	5																							
Brokerage code																								
Broker name																								
Broker code																								
DECLARATION																								
I																								
am duly authori Furthermore, I r																							<u>.</u>	
and indemnify r	ny sele	cted br	rokerag	ge / bro	ker, as	s well a	s Bestr	ned Me	edical S	Scheme	agains	st any c	laims o	or dama	ages su	ffered	as a re	sult of	disclo	sing the	inforn	nation.	•	
Signature of ma	iin mer	nber											Signa	ature o	f broke	r								
Signed at															Date	5	D	D	M	M	Υ	Y	Υ	Υ
. CALCULAT	ION	OF M	ONT	HLY	CON	TRIB	UTIO	N																
CALCULATION OF MONTHLY CONTRIBUTION  PLEASE NOTE: This section should only be completed if your change is subject to approval from your Human Resources department																								
PLEASE NOT	e: Inis	s secti	ion sh	ould	only l	be con	nplete	ed if y	our c	hange	is su	bject	to ap <sub>l</sub>	prova	l from	your	Hum	an Re	sourc	es de	partn	nent		
1. Employer sub				ould	only l	be cor	nplete	ed if y	our c	hange	e is su	bject	to ap <sub>l</sub>	prova	<b>I from</b>	your	Hum	an Re	sourc	es de	partn	nent		
	sidy pe	er mont	:h	ould	only l	be cor	mplete	ed if y	our c	hange	is su	bject i	to ap <sub>l</sub>	prova		your	Hum	an Re	esourc	es de	partm	nent		
1. Employer sub	sidy pe	er mont contribi	h ution		only l	be con	mplete	ed if y	our c	hange	e is su	bject :	to apį	prova	R	your	Hum	an Re	esourc	ces de	partm	·		
Employer sub     Member's mo	onthly o	er mont contribi	h ution		only l	be con	mplete	ed if y	our c	hange	e is su	bject	to app	prova	R R	your	Hum	an Re	esourc	res de	partm	nent		
Employer sub     Member's mo     TOTAL MONTHI	onthly o	er mont contribi	h ution		only l	be con	nplete	ed if y	our c	hange	: is su	bject :			R R R						partm	Yes		No
Employer sub     Member's mo     TOTAL MONTHI     Employer name     Date	onthly o	er mont contribu	th ution	1-2)					our c	hange	e is su	bject			R R						partm			No
1. Employer sub 2. Member's mo TOTAL MONTHI Employer name Date  EMPLOYER A	onthly o	er mont contribu	th ution	1-2)					our c	hange	e is su	bject			R R R						partm			No
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1. Employer sub 2. Member's mo TOTAL MONTHI Employer name Date  EMPLOYER A Name Surname Tel number  Signature of	D  APPRO  f emplo	er mont contribu	th ution	M						hange	? is su	bject		oroval fi	R R	man R	esourc	es depi	artmer	t		Yes		
1. Employer sub 2. Member's mo TOTAL MONTHI Employer name Date  EMPLOYER A Name Surname Tel number  Signature of	PAPPRO F emplo	TRIBUTO D D D D D D D D D D D D D D D D D D D	mution (*)	11-2) M	Y	Y	Y	Y					Арг	oroval fi	R R R	man R	esourc	es depart	artmen	t M	Y	Yes		
1. Employer sub 2. Member's mo TOTAL MONTHI Employer name Date  EMPLOYER I Name Surname Tel number  Signature of	APPRO  f emplo	TRIBUTO DE LA CONTROL DE LA CO	TION (*	11-2)  M  YER	only	Y Y	Y	Y					Арг	oroval fi	R R R	man R	esourc	es depart	artmen	t M	Y	Yes		
1. Employer sub 2. Member's mo TOTAL MONTHI Employer name Date  EMPLOYER A Name Surname Tel number  Signature of	APPRO  f emplo  E: This	TRIBUTO DE LA CONTROL DE LA CO	TION (*	11-2)  M  YER	only	Y Y	Y	Y					Арг	oroval fi	R R R	man R	esourc	es depart	artmen	t M	Y	Yes		

- 1. Hereby warrant that, in as far as we provide Bestmed with any Personal Information and/or Special Personal Information ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA), pertaining to our employees, their dependants, spouse(s) and/or children, we do so with the express informed consent of such employee.
- 2. We hereby confirm that in as far as we provide Bestmed with the Personal Information of any Third Party as contemplated in clause 1 above, we do so in our capacity as "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.
- 3. We hereby expressly make the following acknowledgements in respect of Bestmed's processing of our Personal Information ("referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):

- 3.1 That we have considered and fully understand the provisions of the Data Protection and Privacy Policy published on Bestmed's website and available on request, thereby fully appreciating the manner in which Bestmed may process our Personal Information and for which purpose(s) Bestmed may process such Personal Information
- 3.2 That through submitting this application as a corporate member / participating employer, we may be providing Bestmed with the Personal Information and/or Special Personal Information of our employees and their spouse(s), children and or other dependant third parties.
- 3.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by us from time
- 3.4 That Bestmed may from time to time, depending on the circumstances, collect our Personal Information, as well as that of our employees and their spouse(s), children and or other dependant third parties from another source other than directly from us.
- 3.5 That we fully appreciate that Bestmed places a high premium on our privacy, as well as the privacy of our employees, their spouse(s), children and or other dependant third parties.
- 3.6 That we 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 our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties shall be processed with a reasonable standard of care as may be expected from Bestmed.
- 3.7 That we fully appreciate that Bestmed will only process our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
- 3.8 That, in accordance with the provisions of Section 18 of POPIA, we have been provided with adequate notification of the processing of our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties by Bestmed, the scope and purpose(s) for such processing, as well as our rights to object to such processing should we elect to do so.
- 3.9 That we acknowledge that the processing of our Personal Information is a mandatory requirement for the existence of a valid medical insurance agreement and for us to enjoy the status of a corporate member / participating employer.
- 4. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, we hereby provide our specific and informed consent to Bestmed for the processing of our Personal Information, for any purpose(s) legitimately connected or related to our application for corporate membership and/or membership as a participating employer, which purpose(s) may include, but not be limited to the following:
  - 4.1 To provide or manage any information, products and/or services requested by us pursuant to our application for membership.
  - 4.2 To establish our needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
  - 4.3 To facilitate the delivery of products and/or services to us as a corporate member / participating employer of Bestmed.
  - 4.4 To administer any claims and premiums pertaining to us.
  - 4.5 To activate any policies or prescribed benefits pursuant to our membership.
  - 4.6 To allocate a unique identifier to us for the purpose of securely storing, retaining, and recalling our Personal Information from time to time, including after our corporate membership or membership as a participating employer is terminated.
  - 4.7 For general administration purposes pertaining to our membership.
  - 4.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards us.
  - 4.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals and pharmacies to facilitate the delivery of products and/or services to us.
  - 4.10 To provide us with health and wellness information throughout the subsistence of our membership.
  - 4.11 To transact with third parties and transfer our Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards us.
  - 4.12 To analyse our Personal Information collected for research and statistical purposes.
  - 4.13 To transfer our Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
  - 4.14 To carry out analysis and profiling of our membership profile.
  - 4.15 To identify other products and services which might be of interest to us, as well as to inform us of such products and/or services.
  - 4.16 To obtain and share information about our credit worthiness with any credit bureau or credit provider's industry association or industry body, which includes information pertaining to our credit history, financial history, judgements, default history and sharing information for purposes of risk analysis, tracing and related purposes.
- 5. In as far as we provide Bestmed with the Personal Information of any third party, including the Personal Information of our employees, their spouse(s), children or other dependants, we hereby warrant that we have acquired the consent of such third party to do so and that we are a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

The representative acting on our behalf herein and facilitating the submission of this application to Bestmed, warrants that he/she is duly authorised to act on our behalf and
to thereby bind us to the terms and conditions related to this application.

Signature of employer

## 9. APPLICATION AND DECLARATION

. Ar	PPLICATION AND DECLARATION												
l her	rewith apply for:												
1. Ch	nange due to continuation as a pensioner												
2. Ch	Change from individual to corporate membership												
3. Ch	Change from corporate to individual membership												
	mowledge that I, as well as my existing dependant(s) shall be bound by the rules of the Scheme as amende itted as the principal member of the membership profile and hereby agree to the rules of the Scheme.	ed from time	to time	I, the u	ndersig	gned, h	ereby a	apply to	be be				
By si form	igning this form, I agree to the terms and conditions of Bestmed's membership and confirm that I have n.	fully read a	nd unde	rstood	each of	the pa	ages in	cluded	in this	i			
		Date	D	D	M	М	Υ	Υ	Υ	Υ			

Signature of principal member

<sup>\*</sup>The Scheme Rules will determine admission and the applicable rates.

## **10. CONSENT PROVISIONS BY APPLICANT**

- 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	
Signature of	applicant	