

3. DEPENDANTS TO BE ADDED

1. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>								Date of birth															
	<input type="text"/>								<input type="text"/>															
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.

Relationship to principal member (Indicate with an 'X')

<input type="checkbox"/> Spouse / common-law spouse	<input type="checkbox"/> Partner / fiancé (complete declaration in section 4)	<input type="checkbox"/> Child (if difference in surname, complete declaration in section 5)	<input type="checkbox"/> Other
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If other, please specify relationship:

(affidavit / legal documents)

2. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>								Date of birth															
	<input type="text"/>								<input type="text"/>															
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

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If other, please specify relationship:

(affidavit / legal documents)

3. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>								Date of birth															
	<input type="text"/>								<input type="text"/>															
SARS tax number	<input type="text"/>																							
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If other, please specify relationship:

(affidavit / legal documents)

4. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
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If other, please specify relationship:

(affidavit / legal documents)

5. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
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If other, please specify relationship:

(affidavit / legal documents)

6. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

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If other, please specify relationship:

(affidavit / legal documents)

4. PARTNERSHIP DECLARATION

Only to be completed if you are registering a partner / fiancé / common-law spouse with a surname that is different to that of the main member.

I

(principal member name and surname) declare that I have established a partnership with

(your partner / fiancé / common-law spouse name and surname)

I declare that we are in a sustained, committed, and serious relationship akin to a marriage, based on objective criteria of mutual dependency and a shared household.

Signed by me

 on this

 day of

 month

 Y

 Y

 Y

 Y
Signature of principal member

5. CHILD DECLARATION

Only to be completed if you are registering a child where the surname differs to the principal member

I

(principal member name and surname) declare that

1.	<table border="1" style="width: 100%; height: 20px;"></table>
2.	<table border="1" style="width: 100%; height: 20px;"></table>
3.	<table border="1" style="width: 100%; height: 20px;"></table>
4.	<table border="1" style="width: 100%; height: 20px;"></table>
5.	<table border="1" style="width: 100%; height: 20px;"></table>
6.	<table border="1" style="width: 100%; height: 20px;"></table>

(all children where surname's differs to principal member) is my / my spouse / my partner(s) biological child.

Signed by me

 on this

 day of

 month

 Y

 Y

 Y

 Y
Signature of principal member

* The Scheme Rules will determine admission and the applicable rates.

6. PREVIOUS MEMBERSHIP STATUS

Please supply ALL previous membership certificates, from a South African registered medical scheme for your dependants, as relevant proof of previous medical aid cover. The submission of previous medical aid certificates will ensure correct and relevant underwriting is applied on your new profile. In the event that you are unable to obtain previous membership certificate(s), Bestmed will accept an affidavit if previous cover exceeds 5 years. Visit www.bestmed.co.za to complete affidavit in the relevant blocks. Please refer to applicant checklist (section2) of this form for more details.

Has your spouse / partner and/or dependant(s) been a member or dependant of a medical scheme?

 Yes

 No

According to the Medical Scheme's Act a member / dependant may not belong to 2 medical schemes at the same time therefore it is imperative that we receive a certificate with a resign date to continue with the registration process.

If "yes" please attach all previous membership certificates

Name of scheme	Member number	Principal member	Dependant	Date from	Date to

7. MEDICAL QUESTIONNAIRE (THIS SECTION IS EXTREMELY IMPORTANT)

PLEASE NOTE THAT ALL FIELDS ARE COMPULSORY.

Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders, irrespective of it being chronic or acute and no matter how insignificant it may seem. **If the answer is YES, please give full details of the person and condition concerned in the space provided.** If the space provided is insufficient, provide the details on a separate page and attach it to this questionnaire, medical reports may be included. **The examples listed under each condition below are not intended as a full list of conditions, disorders or symptoms, but only serve as examples. In other words, the examples below are only a limited list and do not include all possible conditions.**

Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? Please clearly specify the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Specify illness / condition / disorder in full	Date of first diagnosis or problem	Date of latest consultation / test / treatments	Please state ALL medicines (name and dosage), nature of treatment, level / stages of illness, hospitalisation, treatment / care / advice / symptoms, dates of last symptoms experienced. Please indicate current problems, symptoms, or the use of assistive or additional therapies as well as planned or required further management	ICD-10 code (if available)
1. Infectious diseases e.g. hepatitis B, tuberculosis, tetanus, bilharzia, etc.	Yes	No						
2. Positive for HIV/AIDS*	Yes	No						
* If you and/or any of your dependants are HIV positive or have AIDS and would prefer not to disclose your and/or their HIV status on this form due to confidentiality, then you must call 012 472 6249 or send an e-mail to mhc@bestmed.co.za in order to notify Bestmed of your and/or your dependant(s) that you and/or your dependants are living with HIV/AIDS. This information must be disclosed to Bestmed within seven (7) working days from the application date of your and/or your dependant(s) membership. On receipt of this request Bestmed will determine whether underwriting conditions will be applied, and if this is the case, you will receive an amended proof of membership document.								
3. Cancer diagnosis/treatment, or a growth or tumour of any kind? Please state type - benign or malignant.	Yes	No						
4. Blood conditions: e.g. anaemia, blood clotting problems, deep vein thrombosis, pulmonary embolism, platelet deficiencies, haemophilia, leukaemia, lymphoma, bleeding disorders.	Yes	No						
5. Endocrine and metabolic conditions : e.g. obesity, diabetes mellitus, porphyria, thyroid problems, Cushing syndrome, metabolic syndrome, Addison disease, any other endocrine or metabolic conditions	Yes	No						
6. Psychiatric conditions: e.g. depression, anxiety, bipolar disorder, autism, Asperger syndrome, sleeping disorders (e.g. narcolepsy), insomnia, eating disorders, drug or alcohol use disorder or rehabilitation, suicide attempt, post-traumatic stress disorder, counselling, recent psychological trauma.	Yes	No						
7. Brain and nervous system or neuromuscular conditions: e.g. paralysis, epilepsy, Parkinson disease, headaches, stroke, cerebral palsy, paraplegia, hemiplegia, carpal tunnel syndrome, chronic headache, migraine, multiple sclerosis, motor neuron disease, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability.	Yes	No						

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8. Eye and eyelid conditions: e.g. vision problems, blurry vision, glasses, cataracts, keratoconus, corneal ulcers, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, corneal transplant, eye surgery, partial or full blindness, astigmatism, any other eye or eyelid condition.	Yes	No						
9. Ear, nose and throat problems: e.g. grommets, otitis media, tinnitus, ear infections, deafness, hearing problems, use of hearing aids, cochlear implant, tonsillitis or adenoiditis, dizziness, vertigo, previous sinus or nasal surgery, sinusitis, deviated nasal septum, allergic rhinitis, chronic blocked nose or sinuses.	Yes	No						
10. Heart and circulation problems: e.g. high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins.	Yes	No						
11. Lung and breathing problems: e.g. asthma, COPD / emphysema, bronchitis, bronchiolitis, pulmonary embolism, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia.	Yes	No						
12. Digestive and gastrointestinal problems: e.g. hiatus /abdominal / inguinal hernia, reflux / heartburn, stomach ulcer, spastic colon, constipation, gallstones, hepatitis, cirrhosis, portal hypertension, alcohol or fatty liver disease, liver failure, pancreatitis, cystic fibrosis, Crohn disease, ulcerative colitis, diverticulitis, jaundice.	Yes	No						
13. Skin condition (including allergies): e.g. eczema, psoriasis, acne, chronic wounds, melanoma, skin cancer, sunspots, warts, skin tags, mole irritation or shape and colour change.	Yes	No						

Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? Please clearly specify the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Specify illness / condition / disorder in full	Date of first diagnosis or problem	Date of latest consultation / test / treatments	Please state ALL medicines (name and dosage), nature of treatment, level / stages of illness, hospitalisation, treatment / care / advice / symptoms, dates of last symptoms experienced. Please indicate current problems, symptoms, or the use of assistive or additional therapies as well as planned or required further management	ICD-10 code (if available)
14. Dental, oral, and maxillofacial consultation and/or treatment: e.g. dental fillings, orthodontics, crowns, dentures, implants, temporomandibular joint disorders, jaw surgery, cleft lip or palate, etc.	Yes	No						
15. Skeletal, joint and muscle deviations / problems: e.g. neck / back / knee / hip problems / pain, arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus (SLE), gout, clubfoot, bunions, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, etc	Yes	No						
16. Kidney and urinary conditions: e.g. kidney failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, etc.	Yes	No						
17. Male reproductive system: e.g. prostate cancer, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, vasectomy, circumcision, erectile dysfunction, etc.	Yes	No						
18. Pregnancy or suspected pregnancy? If yes, please confirm gestation / duration of pregnancy. Are you currently undergoing treatment towards getting pregnant? Provide date of last menstrual period (LMP).	Yes	No						
19. Female reproductive system: e.g. endometriosis, menstrual problems or irregularities, infertility, hormone replacement therapy, sterilisation / hysterectomy, abnormal Pap smear result, polycystic ovarian syndrome, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, etc.	Yes	No						
20. Congenital deviations: e.g. bat ears, cleft palate, patent ductus arteriosus (PDA), heart defects, Down syndrome, neural tube defects, spina bifida, brain defects, ventricular septum defect (VSD), etc.	Yes	No						
21. Rare disorders / conditions: e.g. congenital disorders of glycosylation, Hunter syndrome, lysosomal storage diseases, Klinefelter syndrome, etc.	Yes	No						

Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? Please clearly specify the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Specify illness / condition / disorder in full	Date of first diagnosis or problem	Date of latest consultation / test / treatments	Please state ALL medicines (name and dosage), nature of treatment, level / stages of illness, hospitalisation, treatment / care / advice / symptoms, dates of last symptoms experienced. Please indicate current problems, symptoms, or the use of assistive or additional therapies as well as planned or required further management	ICD-10 code (if available)
22. Any symptoms experienced, or other illness/medical condition that you are aware of not mentioned above, even if no doctor was consulted and irrespective of treated with lifestyle changes or self-medication?	Yes	No						
23. Current medication used, not yet stated above, even if not on a chronic basis. If yes, please attach a list if this space is not sufficient.	Yes	No						
24. Any previous operations undergone?	Yes	No						
25. A condition for which you and/or your dependant(s) received a payment and/or medical treatment of whatever nature: e.g. third party claim.	Yes	No						
26. Any other medical condition or ongoing treatment / monitoring that is not mentioned on the application form that may result in a claim within the next 12 months?	Yes	No						

Important: It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all the dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. Any misstatement in, or omission from this form whether wilful or in ignorance may lead to refusal to admit any claims, suspension or termination of membership. Should a new medical condition arise between the time of completing this application form and the commencement date of membership, the Scheme must be informed immediately. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact **Bestmed's Contact Centre on 086 000 2378.**

Signed by me

Signature of principal member

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day of

8. UNDERWRITING POLICY

It is important to note that proof of previous membership may prevent possible waiting periods being imposed:

The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a Dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application:

- A general waiting period of up to 3 (three) months;
- A condition-specific waiting period of up to 12 (twelve) months.

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:

- A condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits; or
- In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application.

- A general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

Bestmed will implement waiting periods and evaluate and/or investigate information and membership in all cases where adverse selection is exercised to obtain specific benefits.

Monitor for possible non-disclosure

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

- a) Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
- b) When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application.

In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation.

In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

Late Joiner Penalty (in terms of Regulation 131 of the Medical Schemes Act (Act 131 of 1998))

Late joiner penalties can be imposed on beneficiaries over the age of 35. Depending on the number of years the beneficiary did not belong to a medical scheme, a late joiner penalty will be added to the members monthly risk contribution. The penalty is calculated on a sliding scale as shown in the table below, based on the total number of years from age 35 being effective 1 April 2001, where a beneficiary did not belong to a medical scheme.

Number of years since age 35 where applicant was not a member of a medical scheme	Penalty
1 - 4 years	0.05 x risk contribution
5 - 14 years	0.25 x risk contribution
15 - 24 years	0.50 x risk contribution
25+ years	0.75 x risk contribution

9. 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. Aside from information which is legally required (such as tax certificates, vital benefit information and claims statements) Bestmed may also send me important information about Bestmed products and services - such as the Bestmed Newsletter and additional benefit information.

Yes	No
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Signature of applicant

10. APPLICATION AND DECLARATION

I herewith apply for:
Recognition of my abovementioned dependants as beneficiary(ies) of the Scheme on the grounds that, to the best of my knowledge:
1. The details in respect of my dependant(s) set out above are true and correct and that they qualify for enrolment as dependant(s) in terms of the Scheme Rules;
2. My aforementioned dependants are fully dependent on me;
3. My aforementioned dependants are in good health, both mentally and physically. Should an applicant be unable to sign the declaration as required in (1) and (2) on account of temporary absence of a dependant or on account of ill health or of a mental or physical disability of such a dependant, full details should be submitted to the Scheme for consideration.

I undertake on behalf of the above mentioned dependant(s) to abide by the Rules of the Scheme.

By signing this form, I agree to the terms and conditions of Bestmed's membership and confirm that I have fully read and understood each of the pages included in this form.

Signed by me		on this			day of		Y	Y	Y	Y
	Signature of principal member					month				

* The Scheme Rules will determine admission and the applicable rates.

***Full risk underwriting is applicable to extended family**

Why do you want to register the dependant(s) on Bestmed Medical Scheme?

Are you responsible for the care and support of your dependant(s)?

Yes	No
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Are you responsible for the dependant(s) daily expenses?

Yes	No
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[illegible]

Main member name and surname

confirm that all the information I submitted is true in every aspect. I understand and agree that submitting any inaccurate information could result in Bestmed terminating the dependant(s) or cancelling the membership. It remains my responsibility as the member to inform the Scheme if the circumstances change, and if the dependant(s) no longer qualifies to be registered as a dependant.

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Member's signature

Dependant's signature (Only applicable if 18 years and older)

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Dependant's signature (If registering a second dependant)

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

* Please include a stamp from a Commissioner of Oath on this document.

Commissioner of Oaths stamp