INDIVIDUAL APPLICATION FORM

1. APPLICANT (PRINCIPAL MEMBER)

Title | **Bestmed join date** D D M M Y Y Y Y

Full name as per ID document

First name

Middle name | Initials

Surname

ID number | Date of birth D D M M Y Y Y Y

Passport number | Gender M F

Country of issue

SARS tax number (mandatory)

Marital status: Unmarried / Married | Date of marriage / divorce D D M M Y Y Y Y

Current employer

Date of employment D D M M Y Y Y Y | Employee number

2. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	Beat1N (Network) †	Pace1
Beat2	Beat2N (Network) †	Pace2
Beat3	Beat3N (Network) †	Pace3
Beat3 Plus		Pace4
Beat4		

Rhythm1 * ‡

Rhythm2 * ‡

Income bracket if you are joining on the Rhythm1 Option

R 0 - R 9 000 monthly	R 9 001 - R 14 000 monthly	R 14 001 and above monthly

Income bracket if you are joining on the Rhythm2 Option

R 0 - R 5 500 monthly	R 5 501 - R 8 500 monthly	R 8 501 and above monthly

* 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 bracket, pending proof of income.

†

Members on any of the BeatN options enjoy an efficiency discount. 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.

‡

Members on a Rhythm option are restricted to the contracted Rhythm designated service provider network. By selecting a Rhythm option you acknowledge and agree that your option is subject to the following:
1. GP network
2. Specialist network (Referral required from network GP)
3. Hospital network

3. HEALTHCARE ADVISOR DECLARATION

1. I declare that I am an accredited Bestmed healthcare advisor, I am a registered advisor in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 to sell Health Service Benefits, and an accredited broker in terms of Section 65 of the Medical Schemes Act.
2. I accept that the applicant has appointed me as his/her healthcare advisor and that he/she is entitled to terminate my services at his/her will.
3. I confirm that the applicant was given my personal details, including my physical and postal address, and contact number.
4. I acknowledge that in terms of Act 131 of 1998 in the Medical Schemes Act (or as amended), a monthly statutory commission will be paid out to me up to a maximum amount as set by the Medical Schemes Act.
5. I declare that there has been no misrepresentation of any fact by me and that, in the event of material or unlawful conduct, I will be responsible for refunding all monies paid in effect of such misrepresentation or conduct.
6. I declare that the applicant is familiar with the information required in the application form and he/she has provided all the correct information.
7. I declare that the advice and support given to the applicant was unbiased and in his/her best interest.
8. I declare that the applicant has personally signed this application form.
9. I am aware of the submission cut-off date for new registrations.

4. SUMMARY OF MONTHLY COST

Failure to complete the below section in full will result in unsuccessful broker commission payments

TOTAL MONTHLY PREMIUM R .

Healthcare advisor name (mandatory)

Healthcare advisor code (mandatory)

(Healthcare advisor name and code are mandatory for commission payments)

Healthcare advisor signature

Date D D M M Y Y Y Y

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Your email address is essential for correspondence.
If possible, please provide your personal email address instead of your work email address.

Telephone number (w)

Cell phone number

Telephone number (h)

Physical address

Address

Street

Suburb

Town / city

Postal code

Please download the Bestmed App for access to your digital membership card on date of registration, and look out for an SMS with a link after registration has been completed.

6. YOUR BANKING DETAILS

DEBIT ORDER FOR MONTHLY CONTRIBUTIONS BANKING DETAILS

For monthly contributions, please complete your debit order deduction banking details below

* Debit order deduction date | 20th | 25th | 1st | *(These are our fixed debit order dates and, unfortunately, we are unable to process debit orders on any other date.)*

Bank

Branch

Branch code | Type of account | Cheque / current | Savings

Account number

Select account holder | Member | Company* | Other*

***If you have selected "COMPANY" or "OTHER" please complete the sections below, including the address section. This is in accordance with SARS legislative requirements.**

COMPANY

Are you the registered owner of the company? | Yes | No

Registered name of company

Type of company (e.g. private)

Entity registration number

OTHER

Title

First name

Middle name

Surname

Account holder ID number

Passport number (for non-SA citizens)

Country of issue

SARS tax number (mandatory) | Date of birth | D | D | M | M | Y | Y | Y | Y

Physical address
(mandatory field for both "COMPANY" and "OTHER")

Postal code

CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details? | Yes | No

If you selected "NO", please complete your claims refund banking details below

Bank

Branch

Branch code | Type of account | Cheque / current | Savings

Account number

Name of the account holder

If account holder differs from principal member, please confirm account holder ID number / passport number for non-SA citizens

Account holder ID number

I/we hereby authorise Bestmed to draw against my/our account with the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account), the contribution amount for the selected benefit option on the above mentioned date or the first working day thereafter. I/we further authorise Bestmed to adjust the amount due as contributions are amended from time to time. All such withdrawals from my/our account by Bestmed shall be treated as though they have been signed by me/us personally. I/we agree to pay bank charges relating to this debit order instruction. This authority may be cancelled by me/us by giving Bestmed one month's notice in writing via email, fax or registered post, starting on the first day of the following calendar month. Should there be a breach of this contract there is a possibility that the member will be held responsible for payments incurred. I/we understand that I/we shall not be entitled to any refunds of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Bestmed. I/we acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorised party. The deduction of debit order will take place in the month before inception date should you choose the 20th or 25th as the debit order date subject to subscriptions payable in advance.

Signature of principal member	Signature of account holder

7. APPLICANT CHECKLIST

Please ensure the following compulsory documents / information are completed and attached.

1. ID / birth certificate/s of member and dependant/s.
2. If the child is older than 24 years, a declaration statement is required. Adult rates will be applicable.
3. To register adopted dependant(s), official legal court documents are mandatory.
4. In the case of extended family (parent, brother or sister, grandchild) - affidavit of dependant(s) with regards to dependency on principal member.
5. Proof of previous medical scheme membership must be provided; this applies to members and all dependants (NB: Previous membership card/s not accepted). The aforesaid proof must contain the period of cover.
6. Upon completing an affidavit, ensure full details are disclosed e.g. applicable dependants, day, month, year, names of previous schemes.
7. If you or any of your dependents have a disability, please complete the ITR-DD SARS form available on the SARS website. Bestmed will not be able to update disability records without the completed ITR-DD form.
8. If you selected a Bestmed Rhythm option, provide proof of income for both the main member and spouse (3 months' payslips or bank statements - not older than 3 months).
9. Ensure that dependant(s) full names and identity numbers are completed. Passport numbers and Country of Issue required for non-SA citizen.
10. Medical questionnaire: ▪ Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, dates of last symptoms experienced, diagnosed condition, medicine and dosage, nature of treatment, level/stages of illness and hospitalisation).
11. Chronic application: ▪ If registered for chronic medication at the previous medical scheme, submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription, approval is subject to protocols.
Please ensure that all applicable pages are fully completed.

Qualifying Criteria of a Dependant

As per Bestmed Scheme Rules, a Dependant is:

- A Member's spouse or partner;
- A Member's dependent child who is under the age of 24 (twenty-four) years;
- A parent, brother, sister or grandchild of a Member in respect of whom the Member is liable for family care and support, and for whom adult Dependants contributions shall be payable if such Dependant is 24 (twenty-four) years of age and older;
- A Member's child who is 24 (twenty-four) years or older in respect of whom the Member is liable for family care and support, or because of a mental / physical handicap or for any similar reason is dependent on the Member and adult Dependant's contribution shall be payable.

For more information on Bestmed rules, please visit our website www.bestmed.co.za

8. DEPENDANTS TO BE ADDED

1. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

2. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

3. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

4. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

5. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

6. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

7. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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')

☐ Spouse / common-law spouse ☐ Partner / fiancé *(complete declaration in section 9)* ☐ Child *(if difference in surname, complete declaration in section 10)* ☐ Other

If other, please specify relationship:
(affidavit / legal documents)

9. 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

Signature of principal member

on this day of month Y Y Y Y

10. 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.
2.
3.
4.
5.

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

Signed by me

Signature of principal member

on this day of month Y Y Y Y

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

11. 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

12. PREVIOUS MEMBERSHIP STATUS

Please supply ALL previous membership certificates, from a South African registered medical scheme for you and 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 (section 7) of this form for more details.

Have you and/or your spouse / partner and/or dependant(s) been a member or dependant of a medical scheme?	Yes	No
I was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months with no break in membership between previous medical scheme and Bestmed, contributions at my previous scheme were paid in arrears therefore I would like to continue to pay Bestmed in arrears.	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

13. 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						

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)
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						

Please note that the complete medical questionnaire does not serve as an application for chronic benefits, kindly download and complete separate chronic application form from our website; if registered for chronic medication at the previous medical scheme, submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription, approval is subject to protocols.

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.**

I _____
(principal member name and surname) acknowledge that all information declared above is true and correct.

Signed by me _____ on this ____ day of month Y Y Y Y

Signature of principal member

14. 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

Signature of applicant

15. STATEMENT OF APPLICANT

I

(principal member name and surname) hereby declare that:

a. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;

b. By signing this form, I agree to the terms and conditions of Bestmed's Beat network options and Rhythm options where applicable.

c. The information furnished herein is completely true and correct to the best of my knowledge and conviction and that I have not omitted or concealed any information; I accept that a savings account will be allocated pro rata (if applicable);

d. I understand that if my application for membership is approved and accepted, the information furnished on my application form will be used as the basis of my application and the payment of benefits in the future;

e. I irrevocably hereby grant permission on behalf of myself as well as on behalf of my dependant(s) (if applicable) to any physician, person or party who may be in possession of or obtain information concerning my state of health or that of my dependant(s), treatment received or expected as well as any other relevant information to divulge such information to Bestmed or its proxy on demand, also after my death or that of my dependant(s); I understand that this information together with other information will be used to evaluate the payment of benefits for certain medical conditions, I warrant that I have obtained my dependant(s) consent to grant this authorisation;

f. I undertake to pay my share of accounts to Bestmed; on default, I hereby authorise my employer / business to deduct the amount due from my salary or should I resign, I hereby authorise my employer / business to deduct the amount due from my pension or any other monies due to me and pay this over to Bestmed;

g. I acknowledge that my date of application does not necessarily refer to my date of admission as a member of Bestmed. I further acknowledge that my date of admission will be communicated to me by Bestmed as soon as possible hereafter.

h. If my health or my dependant's health changes or gets worse before the latest of these three dates — the membership start date set by Bestmed, the date Bestmed approves the application, or the date they receive the first payment — then Bestmed has the right to review the application again and may offer different membership terms.

i. If after or during my admission as a member of Bestmed it is found that any statement or information furnished by me was knowingly and/or wilfully inadequate, incomplete or untrue, Bestmed reserves the right to cancel the membership. If such is the case, I agree to refund in full to Bestmed all payments which Bestmed may have made on my behalf and to relinquish any claim to any benefits on the part of Bestmed;

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

Signature of applicant

Signed at | on this | day of | month | Y | Y | Y | Y

Cut-off date for submission of new applications is the 27th of the month, this is to secure the following months start date. Incomplete applications or missing documents may impede the start date.