NEW MEMBER APPLICATION FORM: BESTMED TO BESTMED

Dependants that were not previously on a Bestmed profile should complete a Registration of Dependants which is available to download from **www.bestmed.co.za**

Previous Bestmed membership number

Please select the reason for completing this form or specify in space provided

Holder swap: Tax purposes		**Holder swap: Employment change**		**Other**	
Divorce		**Overage dependant continuation**			
Member passed away, dependant continuation as principal member					

1. APPLICANT (PRINCIPAL MEMBER)

Title

Registration start 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)

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. DEPENDANTS TO BE ADDED FROM PREVIOUS PROFILE

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)

8. 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.

   Note: If no selection is made, the Scheme will automatically send the information to you by default.

Yes	No

9. STATEMENT OF APPLICANT

I

(principal member name and surname) hereby declare that:

1. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;
2. By signing this form, I agree to the terms and conditions of Bestmed's Beat network options and Rhythm options where applicable.
3. 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.
4. 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; I accept that a savings account will be allocated pro rata (if applicable);
5. 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;
6. 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;
7. 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.
8. 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.
9. 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

10. HR PRACTITIONER DETAILS

Surname

Full names

Email

Telephone number

State that the applicant

a. Has been **permanently** employed by us since D D M M Y Y Y Y

b. Bestmed membership to start D D M M Y Y Y Y

c. Department

d. Employee number

e. Total monthly contribution to be paid to Bestmed R .

Remarks

Signature of HR practitioner

Name stamp of employer

Date D D M M Y Y Y Y