EXTENDED FAMILY AFFIDAVIT CONFIRMING FINANCIAL DEPENDENCY

AFFIDAVIT (PARENT / BROTHER / SISTER / GRANDCHILD) *To be completed by the main member*

***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

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

I

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.

Member's signature

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

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

© Bestmed Medical Scheme
Bestmed Medical Scheme is an Authorised Financial Services Provider (FSP no. 44058)

HR PRACTITIONER DETAILS (CORPORATES ONLY)

Surname

Full names

Email

Telephone

Remarks

Signature of HR practitioner

Date D D M M Y Y Y Y

Name stamp of employer