TERMINATION OF CORPORATE MEMBERSHIP / DEPENDANT

- This form is to be completed by members who wish to advise the Scheme of termination of membership.
- Should the member join another medical aid as a main member on a savings option, the remaining savings balance (if any) will be transferred to your new medical aid.
- Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme, or be admitted to membership of another medical scheme which does not provide for a Personal Medical Savings Account (PMSA), the balance due to the member, including interest earned, must be refunded to the member five (5) months after termination of membership, subject to receiving the required documentation and will be subject to applicable laws.
- Where a member was registered on a savings benefit option and has exceeded the available savings allocation at the time of termination, the member shall remain liable for the value of the overutilised savings.
- Any amount owed to the Scheme (e.g. overutilised savings, share of any account and/or contributions) shall be recovered in accordance with the Scheme's Rules.

1. DETAILS OF MEMBER

Membership number

Employee number

Title

First name

Middle name

Initials

Surname

Telephone number (w)

Cell phone number

New email
if available

Current employer

1.1 Terminate the full membership:

☐ I hereby tender my resignation and that of all my dependants from Bestmed effective from

D D M M Y Y Y Y

or

1.2 Terminate a specific dependant:

☐ I hereby tender the resignation of my dependant/s:

First name	ID / Passport number	Resignation date

2. REASON FOR TERMINATION

Please indicate the relevant reason(s) with an 'X'

Finance related	
Affordability	
Service and benefit related	
Insufficient benefits / cover	
Network no access to providers	
Poor service (administrative related)	

Life event	
Death	
Emigration	
Joining spouse's scheme	
New employer (join compulsory scheme)	
Change from member to dependant	
Change from dependant to member	

I will be joining the following medical scheme

From D D M M Y Y Y Y

Signed by me

Signature of principal member

on this day of month Y Y Y Y

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

3. PRIVACY NOTICE TO MEMBERS

By virtue of your membership, and that of your dependent(s), you have agreed to the terms of Bestmed Medical Scheme's Data Protection and Privacy Policy and have acknowledged that Bestmed Medical Scheme will process your personal information, as contemplated in terms of the provisions of the Protection of Personal Information Act, 4 of 2013 (POPIA) for various purposes associated with your membership.

Pursuant to your membership, the initial purpose for processing your personal information, or that of your dependent(s), was to onboard you [and where applicable your dependent(s)] as member(s) of the Bestmed Medical Scheme, and to thereafter administer prescribed benefits associated with such membership. By virtue of the termination of your [and where applicable your dependent(s)] membership, the initial purposes associated with processing your personal information will no longer be applicable.

However, please note that the Bestmed Medical Scheme cannot simply by virtue of this termination cease to process your [and where applicable your dependent(s)] personal information, as we are required to process your personal information for various other purposes. For example, the Bestmed Medical Scheme will store and retain your personal information for periods required in accordance with Bestmed Medical Scheme's legitimate retention periods and business interests, including for purposes of refunds in respect of unused medical savings, debit activities, estate late purposes, research and statistical purposes, as well as for periods necessary to comply with our legal and statutory obligations related to the storage of specific types of records and/or information.

You have certain rights when it comes to your personal information held by the Bestmed Medical Scheme, even after this termination, but bear in mind that there may be various considerations in deciding how to deal with any requests you may have. Contact us at 086 000 2378, so that our Information Officer is able to review and/or process any request you may have and provide a response.

Your rights include:

- **Right of Access** - You can ask for a copy of the personal information we hold.
- **Right to Know** - You can ask what purposes we still process your personal information for.
- **Right to Change** - You can ask to update your personal information or delete any personal information that is no longer accurate or relevant.
- **Right to Object** - You can object to our processing of your personal information.
- **Right to Report** - You can lodge a complaint with the relevant authorities should you feel aggrieved by the manner in which we have processed your Personal Information.

By completing this form in my capacity as a member, I acknowledge that I understand that I am providing Bestmed Medical Scheme with the above personal information for the specific purpose of terminating my membership [or where applicable that of my dependent(s)].

In as far as I provide Bestmed Medical Scheme with the personal information of any third party, including my spouse(s), children or other dependents, I hereby warrant that I have acquired the consent of such third party to do so and that I am a "competent person" in respect of such personal information, as contemplated in terms of the provisions of POPIA.

Despite this termination, I hereby acknowledge that Bestmed Medical Scheme will allocate a unique identifier to my membership profile for purposes of recalling material particulars of my membership profile in accordance with the Scheme's retention policy.

Signature of member

4. PRIVACY NOTICE TO EMPLOYER

To be completed by Employer **(ALL FIELDS COMPULSORY)**

By virtue of your position as the employer of the aforesaid member(s), you have agreed to the terms of Bestmed Medical Scheme's Data Protection and Privacy Policy and have acknowledged that Bestmed Medical Scheme will process any personal information, as contemplated in terms of the provisions of the Protection of Personal Information Act, 4 of 2013 (POPIA) for various purposes associated with your employees membership.

Pursuant to the aforesaid membership, the initial purpose for processing the member(s) personal information, or that of their dependent(s), was to onboard them [and where applicable their dependent(s)] as member(s) of the Bestmed Medical Scheme, and to thereafter administer prescribed benefits associated with such membership. By virtue of the termination of their [and where applicable their dependent(s)] membership, the initial purposes associated with processing their personal information will no longer be applicable.

However, please note that the Bestmed Medical Scheme cannot simply by virtue of this termination cease to process their personal information, as we are required to process such personal information for various other purposes. For example, the Bestmed Medical Scheme will store and retain the personal information of members for periods required in accordance with Bestmed Medical Scheme's legitimate retention periods and business interests, including for purposes of refunds in respect of unused medical savings, debit activities, estate late purposes, research and statistical purposes, as well as for periods necessary to comply with our legal and statutory obligations related to the storage of specific types of records and/or information.

ACKNOWLEDGEMENT BY EMPLOYER:

By completing this form in our capacity as an employer of the aforesaid member(s),

I

the duly authorised representative of the member(s) employer, acknowledge that I am providing Bestmed Medical Scheme with the above personal information for the specific purpose of confirming the termination of the above membership [or where applicable that of the member's dependent(s)].

Signature of employer

5. HR PRACTITIONER DETAILS

Employee number

HR practitioner details

Surname

Full names

Email

Telephone number

Remarks

Signature of HR practitioner

Date D D M M Y Y Y Y

Name stamp of employer