# TELKOM APPLICATION FORM

## 1. APPLICANT (PRINCIPAL MEMBER)

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

First name

Middle name | Initials

Surname

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

Home language

Passport number | Gender M F

Country of issue (passport)

SARS tax number (SARS legislative requirement)

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

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 | Rhythm1 * ‡ |
| Beat2 | Beat2N (Network) † | Pace2 | Rhythm2 * ‡ |
| Beat3 | Beat3N (Network) † | Pace3 | |
| Beat3 Plus | | Pace4 | |
| Beat4 | | | |

**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 |

* Please note that you will be registered on the highest interval, pending confirmation from your HR.

† 

| **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. Primary care service provider network |
| 2. Specialist network |
| 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.

## 4. SUMMARY OF MONTHLY COST

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

1. Total high risk premium (principal member or principal member and spouse/partner and child dependants) R . 

2. Total monthly medical savings account R . 

3. Extended family (including monthly savings) R . 

**MONTHLY TOTAL (1-3)** R . 

Healthcare advisor name

Healthcare advisor code

Healthcare advisor signature

Date D D M M Y Y Y Y

## 5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Telephone number (w)

Fax number

Telephone number (h)

Cellphone number

Is your home address the same as your postal address? Yes No

**Home address details**

Address

Street

Suburb

Town/city

Postal code

**Postal address details (Domicilium citandi et executandi)**

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

### CLAIMS REFUND BANKING DETAILS

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's ID number

Signature of applicant

Signature of account holder (if different from applicant)

## 7. 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ 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

***Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

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

## 8. 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) and that we have been living together since D D M M Y Y Y Y

I declare that we intend to continue living together indefinitely, and I undertake to inform Bestmed within 30 days in the event of termination of this partnership.

Signed by me

Signature of principal member

on this day of month Y Y Y Y

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

1.
2.
3.
4.
5.

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.

## 10. UNDERWRITING POLICY

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

Bestmed will do NO risk underwriting in respect of staff of participating employers who apply for registration as Principal members within 90 (ninety) days of the date of permanent appointment, marriage or divorce.

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 |

## 11 . PREVIOUS MEMBERSHIP STATUS

**Please supply previous membership certificates, from a South African registered medical scheme, 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.**

Have you and/or 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.**

**If "yes" please attach all previous membership certificates**

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

## 12. MEDICAL QUESTIONNAIRE

**12.1 This section is extremely important:**
**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 | Date of last consultation/ test/treatment | Please state medicine and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms |
|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |
| 14. Oral, maxillofacial and dental treatment: e.g. dental fillings, braces, crowns, dentures, 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? | 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 | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 the Scheme should be aware of 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

Signature of principal member

on this

day of

month Y Y Y Y

## 13. 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. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

| Yes | No |
|---|---|

Signature of applicant

## 14. APPLICANT CHECKLIST

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

| |
|---|
| 1. If a child is older than 24, proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant. If a child is older than 24 and unemployed, a declaration statement is required and adult rates will apply. |
| 2. In the case of extended family (parent, brother or sister, grandchild) - affidavit of dependant(s) with regards to dependency on principal member. |
| 3. 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. |
| 4. In the case of a handicapped dependant, a report from a medical practitioner. |
| 5. If you selected a Bestmed Rhythm option, provide proof of income (3 months' payslips or bank statements - not older than 3 months). |
| 6. Ensure that dependant(s) full names and identity numbers are completed. Passport numbers and Country of Issue required for non-SA citizen. |
| 7. Medical questionnaire:<br>▪ Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, diagnosed condition, medicine and dosage, nature of treatment, level/stages of illness and hospitalisation). |
| 8. Chronic application:<br>▪ 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. |
| 9. Upon completing an affidavit, ensure full details are disclosed e.g. day, month, year, names of previous schemes. |

## 15. STATEMENT OF APPLICANT

I

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. Any deterioration or change in my state of health or in that of my dependant(s) before the date or event to be set by Bestmed for commencement of membership, or the date of acceptance of this application by Bestmed, or the date of receipt of the first subscription, whichever date is the latest shall entitle Bestmed to reconsider the application and propose new terms of admission.

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