MAIN MEMBER AND MAJOR DEPENDANT MANAGED HEALTHCARE CONSENT FORM

1. MAIN MEMBER CONSENT

I,

Membership number

hereby give consent to Bestmed Medical Scheme ("Bestmed") to process my Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013, for purposes of managing the following medical condition(s) :

CHRONIC CONDITIONS					
Addison's disease		Crohn's disease		Hypertension	
Asthma		Diabetes insipidus		Hypothyroidism	
Bipolar mood disorder		Diabetes mellitus type 1		Multiple sclerosis	
Bronchiectasis		Diabetes mellitus type 2		Parkinson's disease	
Cardiomyopathy		Dysrhythmias		Rheumatoid arthritis	
Chronic renal disease		Epilepsy		Schizophrenia	
Chronic obstructive pulmonary disease (COPD)		Glaucoma		Systemic lupus erythematosus (SLE)	
Cardiac failure		Haemophilia		Ulcerative colitis	
Coronary artery disease		Hyperlipidaemia			
NON-CDL CONDITIONS					
Acne - severe		Urinary incontinence		Neuropathy	
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)		Gastro-oesophageal reflux disease (GORD)		Polyarteritis nodosa	
Allergic rhinitis		Paget's disease		Scleroderma	
Eczema		Ankylosing spondylitis		Sjogren's disease	
Migraine prophylaxis		Hypopituitarism		Trigeminal neuralgia	
Gout prophylaxis		Osteoarthritis		Psoriatic arthritis	
Major depression		Alzheimer's disease		Blepharospasm	
Obsessive compulsive disorder		Collagen diseases		Dystonia	
Osteoporosis		Dermatomyositis			
Psoriasis		Motor neuron disease			
PMBs					
Aplastic anaemia		Female menopause		Paraplegia/Quadriplegia	
Chronic anaemia		Fibrosing alveolitis		Polycystic ovarian syndrome	
Benign prostatic hypertrophy		Graves' disease		Pulmonary embolism	
Cushing's disease		Hyperthyroidism		Stroke	
Cystic fibrosis		Hypophyseal adenoma			
Endometriosis		Idiopathic trombocytopenic purpura			
DISEASE MANAGEMENT					
Back and neck care		Dialysis care		Maternity care	
Oncology care		Diabetes care			
HIV/AIDS care		Heamatology			
SUPPORT SERVICES					
Alcohol and substance abuse care		Wound care		Stoma care	
OTHER (PLEASE SPECIFY)					

1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to my health, medical and treatment records.
2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage my condition(s) as indicated above.
3. I further expressly give informed consent for Bestmed to obtain my Personal/Special Personal Information from any party who may be in possession of information relating to my state of health, treatment received or expected, as well as any other information that may be in possession of that party which Bestmed may deem relevant for the management of my condition(s).
4. I confirm that I am aware of the fact I can revoke my consent for the processing of my Personal/Special Personal Information, at any time by written communication to Bestmed. I also understand that me revoking my consent may result in Bestmed not being able to adequately render medical aid services to me.
5. I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Personal/Special Personal Information.

2. CONSENT ON BEHALF OF MAJOR DEPENDANT (18 AND ABOVE)

I,

Membership number

in my representative capacity as the Spouse/Partner/Parent/Guardian/Other (Please specifiy)

of

ID number

hereby give consent to Bestmed Medical Scheme ("Bestmed"") to process my Dependant's Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013, for purposes of management of the following medical condition(s) :

CHRONIC CONDITIONS					
Addison's disease		Crohn's disease		Hypertension	
Asthma		Diabetes insipidus		Hypothyroidism	
Bipolar mood disorder		Diabetes mellitus type 1		Multiple sclerosis	
Bronchiectasis		Diabetes mellitus type 2		Parkinson's disease	
Cardiomyopathy		Dysrhythmias		Rheumatoid arthritis	
Chronic renal disease		Epilepsy		Schizophrenia	
Chronic obstructive pulmonary disease (COPD)		Glaucoma		Systemic lupus erythematosus (SLE)	
Cardiac failure		Haemophilia		Ulcerative colitis	
Coronary artery disease		Hyperlipidaemia			
NON-CDL CONDITIONS					
Acne - severe		Urinary incontinence		Neuropathy	
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)		Gastro-oesophageal reflux disease (GORD)		Polyarteritis nodosa	
Allergic rhinitis		Paget's disease		Scleroderma	
Eczema		Ankylosing spondylitis		Sjogren's disease	
Migraine prophylaxis		Hypopituitarism		Trigeminal neuralgia	
Gout prophylaxis		Osteoarthritis		Psoriatic arthritis	
Major depression		Alzheimer's disease		Blepharospasm	
Obsessive compulsive disorder		Collagen diseases		Dystonia	
Osteoporosis		Dermatomyositis			
Psoriasis		Motor neuron disease			
PMBs					
Aplastic anaemia		Female menopause		Paraplegia/Quadriplegia	
Chronic anaemia		Fibrosing alveolitis		Polycystic ovarian syndrome	
Benign prostatic hypertrophy		Graves' disease		Pulmonary embolism	
Cushing's disease		Hyperthyroidism		Stroke	
Cystic fibrosis		Hypophyseal adenoma			
Endometriosis		Idiopathic trombocytopenic purpura			

DISEASE MANAGEMENT					
Back and neck care		Dialysis care		Maternity care	
Oncology care		Diabetes care			
HIV/AIDS care		Heamatology			
SUPPORT SERVICES					
Alcohol and substance abuse care		Wound care		Stoma care	
OTHER (PLEASE SPECIFY)					

1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to the health, medical and treatment records of my Dependant.
2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage the condition(s) of my Dependant, as indicated above.
3. I further expressly give consent for Bestmed to obtain any Personal/Special Personal Information of my Dependant from any party who may be in possession of information relating to my Dependant's state of health, treatment received or expected, as well as any other information that may be in possession of that party that may be deemed relevant by Bestmed for the management of my Dependant's condition(s).
4. I warrant that by giving consent on behalf my Dependant, I have acquired the required consent to do so from my Dependant.
5. I confirm that I am aware of the fact I can revoke my consent for the processing of the Personal/Special Personal Information of my Dependant, at any time by written communication to Bestmed. I also understand that me revoking this consent may result in Bestmed not being able to adequately render medical aid services to my Dependant.
6. Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Dependant's Personal/Special Personal Information.

Signature

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