## MAIN MEMBER AND MAJOR DEPENDANT MANAGED HEALTHCARE CONSENT FORM



. MAIN M	EMB	ER	COI	VSEN	IT																						
		,																									
l,																											
Membership	numh	ωr																									
riembersinp	Hullib	E																									
hereby give																		Inform	ation	as de	efine	d in	the	Prote	ction	of	
Personal In	nforma	tior	Act,	4 of 2	01	3, for	purpo	ses o	f man	aging	the fo	ollowi	ng me	edical	cond	ition(s	5):										
CHRONIC	CONDI	TIO	NS																								
Addison's disease								Cı	ohn's	disea	se						Н	perte	nsion								
Asthma								Di	abete	s insi	oidus							pothy		m							
Bipolar mo	od disc	orde	r					Di	abete	s mell	itus t	ype 1					М	ultiple	sclero	osis							
Bronchiect	asis							Di	abete	s mell	itus t	ype 2					Pa	arkinso	n's di	sease							
Cardiomyo	pathy							D	ysrhyt	hmias	5						RI	neuma	toid a	rthriti	is						
Chronic re	nal dis	eas	e					Ep	oileps	/							Sc	hizopl	hrenia								
Chronic obstructive pulmonary disease (COPD)								GI	Glaucoma										c lupu	s eryt	hem	ato	sus (	SLE)			
Cardiac failure								Н	aemoj	hilia		UI	Ulcerative colitis														
Coronary artery disease								H	yperli	oidaer	nia																
NON-CDL	CONDI	TIO	NS																								
Acne - severe							U	Urinary incontinence										Neuropathy									
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)						0)		Gastro-oesophageal reflux disease (GORD)									Polyarteritis nodosa										
Allergic rhinitis							Pa	Paget's disease										Scleroderma									
Eczema								A	Ankylosing spondylitis										Sjogren's disease								
Migraine p	rophyla	axis						H	Hypopituitarism										Trigeminal neuralgia								
Gout proph	nylaxis							0:	Osteoarthritis										Psoriatic arthritis								
Major depr	ession							A	Alzheimer's disease										Blepharospasm								
Obsessive	compu	ılsiv	e dis	order				Co	Collagen diseases										Dystonia								
Osteoporo	sis							D	Dermatomyositis																		
Psoriasis								М	otor n	euron																	
PMBs																										,	
Aplastic an	naemia										pause						Pa	araple	gia/Qu	ıadrip	legia						
Chronic and	aemia							Fi	Fibrosing alveolitis									Polycystic ovarian syndrome									
Benign pro			ertro	phy					Graves' disease									ılmona	ary en	nbolisi	n						
Cushing's o		5							Hyperthyroidism									roke									
Cystic fibro									Hypophyseal adenoma																		
Endometri								ld	iopatl	nic tro	mboc	ytope	nic pu	irpura													
DISEASE N			IENT																								
Back and n		re							Dialysis care									Maternity care									
Oncology o									Diabetes care																		
HIV/AIDS c								Heamatology																			
SUPPORT																											
Alcohol and	d subs	tano	e ab	use ca	e			W	ound	care							St	oma ca	are								

**OTHER (PLEASE SPECIFY)** 

<sup>•</sup> Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, RSA • PO Box 2297, Pretoria, 0001, RSA • Client Service 086 000 2378 • Fax +27 (0)12 472 6500 • E-mail membership@bestmed.co.za • www.bestmed.co.za • Reg no. 1252

- 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)

l,																					
Membership number																					
in my representative capacity as	ny representative capacity as the Spouse/Partner/Parent/Guardian/Other (Please specifiy)																				
of																					
ID number																					
	nereby 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):															he					
CHRONIC CONDITIONS																					
Addison's disease			Cr	Crohn's disease										nsion							
Asthma			Di	abete	s insip	oidus						Hy	pothy	/roidis	m						
Bipolar mood disorder			Di	abete	s mell	itus t	ype 1					Mı	ıltiple	scler	osis						
Bronchiectasis			Di	abete	s mell	itus t	ype 2					Pa	Parkinson's disease								
Cardiomyopathy	Dy	Dysrhythmias										Rheumatoid arthritis									
Chronic renal disease	Ер	ilepsy	1							Sc	Schizophrenia										
Chronic obstructive pulmonary (COPD)	Gla	aucom	ıa							Sy	Systemic lupus erythematosus (SLE)										
Cardiac failure	Ha	emop	hilia							UI	Ulcerative colitis										
Coronary artery disease	Ну	perlip	idaen	nia																	
NON-CDL CONDITIONS																					
Acne - severe			Ur	inary	incon <sup>-</sup>	tinend	:e					Neuropathy									
Attention deficit disorder/ Attendeficit hyperactivity disorder (A			istro- ORD)	oesop	ohage	al ref	lux di	seas	е		Po	Polyarteritis nodosa									
Allergic rhinitis			Pa	get's	disea	se						Sc	Scleroderma								
Eczema			Ar	ıkylos	ing sp	ondyl	itis					Sj	Sjogren's disease								
Migraine prophylaxis			Ну	popit	uitari	sm						Tr	Trigeminal neuralgia								
Gout prophylaxis			Os	teoar	thritis	5						Ps	Psoriatic arthritis								
Major depression			Ala	zheim	er's d	isease	2					BI	Blepharospasm								
Obsessive compulsive disorder			Со	llager	n disea	ases						Dy	Dystonia								
Osteoporosis			De	rmato	myos	itis															
Psoriasis			Мо	otor n	euron	disea	se														
PMBs																					
Aplastic anaemia	Fe	male	meno	pause						Paraplegia/Quadriplegia											
Chronic anaemia	Fil	Fibrosing alveolitis									Polycystic ovarian syndrome										
Benign prostatic hypertrophy	Gr	aves'	diseas	se						Pulmonary embolism											
Cushing's disease			Ну	perth	yroid	ism						Stroke									
Cystic fibrosis			Ну	Hypophyseal adenoma																	
Endometriosis	ldi	opath	ic tro	mbocy	/topei	nic pu	rpura								_	_					

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	Υ	Υ	Υ	Υ