ESKOM 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 | Unique number

2. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	Beat1N (Network) †	Pace1	Rhythm1 * ‡
Beat2	Beat2N (Network) †	Pace2	Rhythm2 * ‡
Beat3	Beat3N (Network) †	Pace3	
Beat4		Pace4	

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 bracket, pending confirmation from your HR.

†

Take note: Members on any of the BeatN options enjoy an efficiency discount. As such, please note that 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.

‡

Take note: Members on a Rhythm option are restricted to the contracted Rhythm designated service provider network. As such, 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)

Telephone number (h)

Fax number

Cellphone number

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

Please take note that all future hard-copy correspondence will be sent to the postal address provided below.

Home address details

Address

Street

Suburb

Town/city Postal code

Postal address details (Domicilium citandi et executandi)

Address

Street

Suburb

Town/city Postal code

Until receiving your membership card/s via post, you are able to download your e-card via the Bestmed app.

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 and proof of income required)

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 and proof of income required)

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 and proof of income required)

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 and proof of income required)

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

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

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If other, please specify relationship:
(affidavit/legal documents and proof of income required)

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 and proof of income required)

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 rules of the Scheme 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(s) or dependant(s) of a medical scheme(s)?

Yes	No

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 Please note: Where the answer is YES, please give full details of the person concerned in the space provided. If you or any of your dependant(s) are suffering from a chronic condition, a medical report is required setting out details of the condition. If the space provided is insufficient, write the details on a separate page and attach it to this questionnaire. The examples listed under each condition below is not intended as a full list of conditions, disorders or symptoms, but only serve as examples. ***The examples listed with each section is only a limited list and does not include all possible conditions.***

Have you or any of your proposed beneficiary-(ies) received any medical advice, diagnosis, care or was recommended for treatment for the following, within the 12- month period ending on the date on which you are applying for membership. ***Please clearly specify/underline*** the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Date diagnosed	Last treatment date	Please state diagnosis, medicine and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms in the last 12 months
1. Congenital physical deviations: e.g. bat ears, valvular heart disease	Yes	No				
2. Skin conditions/abnormalities (including allergies): e.g. eczema, psoriasis, acne	Yes	No				
3. Skeletal, joint and muscle deviations/problems: e.g. arthritis, back/knee problems, jaw surgery/ problems	Yes	No				
4. Sensory organ problems: hearing, speech, vision (including spectacles and/or contact lenses)	Yes	No				
5. Lung/respiratory problems: e.g. asthma, COPD, bronchitis, bronchiolitis, pulmonary embolism	Yes	No				
6. Heart/Cardio-vascular problems: e.g. hypertension, high cholesterol, heart failure, thrombosis, bypass surgery	Yes	No				
7. Digestive problems: e.g. hiatus hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, liver or pancreas problems	Yes	No				
8. Urinary system problems: e.g. kidney infections/failure/dialysis/stones, bladder problems/infection, incontinence	Yes	No				
9. Metabolic diseases: e.g. obesity, diabetes type 1 or 2, porphyria, thyroid problems	Yes	No				
10. Mental / psychiatric problems: e.g. depression, anxiety, bipolar mood disorder, sleeping disorders, counselling	Yes	No				
11. Muscular/nervous system: e.g. paralysis, epilepsy, Parkinson's disease, headaches, Stroke, cerebral palsy, paraplegia, hemiplegia, amputations	Yes	No				
12. Substance abuse/dependence: e.g. alcohol, drugs, recent rehabilitation	Yes	No				
13. Cancer diagnosis/treatment, a growth or tumour of any kind? Please state type.	Yes	No				
14. Dental treatment: e.g. fillings, braces, crowns, dentures	Yes	No				
15. Ear, nose and throat problems: e.g. grommets, tonsillitis, sinus/nasal surgery, sinusitis	Yes	No				
16. Any previous operations undergone?	Yes	No				

17. Any other medical condition or ongoing treatment/monitoring that the Scheme should be aware of?	Yes	No				
18. 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				
19. Contagious diseases e.g. positive for HIV/AIDS*, hepatitis B, tuberculosis	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.

20. 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				
21. Any symptoms experienced in the last 12 months, or other illness or medical condition that you are aware of and not mentioned above, even if you or your dependant(s) did not consult a doctor?	Yes	No				

22. For males only						
22a. Male reproductive system: e.g. prostate/testes problems, vasectomy, circumcision	Yes	No				
22b. Male hormone system: e.g. hormone replacement therapy	Yes	No				
23. For females only						
23a. Pregnancy or suspected pregnancy. If yes, please confirm gestation	Yes	No				
23b. Female reproductive system: e.g. endometriosis, menstrual problems/irregularities, infertility, hormone replacement therapy, sterilisation/hysterectomy	Yes	No				

12.2 Are you and/or your dependant/s currently using any chronic medicine?

Yes | No

If you have answered YES, please complete the separate chronic application form on the website. If registered for chronic medication at the previous medical scheme, please submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription. Important to note: Failure to submit information will result in chronic medicine being paid from acute medicine.

PLEASE NOTE:

- Chronic benefits are granted in accordance with the applicable underwriting.
- Chronic benefits are granted according to the Bestmed formulary per condition per benefit option.
- The formularies are available on the Bestmed website at www.bestmed.co.za
- If non-formulary medicine does qualify for benefits, it will be subject to an additional co-payment.

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. The Medical Schemes Act makes provision for a membership to be terminated where non-disclosure of material information is proven and the law does not recognise ignorance as an excuse. 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 _____ on this _____ day of month Y Y Y Y

Signature of principal member

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. THE FOLLOWING DOCUMENTS/INFORMATION ARE COMPULSORY

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 only) - 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 Rhtyhm 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: ▪ 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. 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

16. STATEMENT BY EMPLOYER

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

We (employer name)																					

1. Hereby warrant that, in as far as we provide Bestmed with any Personal Information and/or Special Personal Information ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA), pertaining to our employees, their dependants, spouse(s) and/or children, we do so with the express informed consent of such employee.

2. We hereby confirm that in as far as we provide Bestmed with the Personal Information of any Third Party as contemplated in clause 1 above, we do so in our capacity as "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

3. We hereby expressly make the following acknowledgements in respect of Bestmed's processing of our Personal Information ("referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):

   3.1 That we have considered and fully understand the provisions of the Data Protection and Privacy Policy published on Bestmed's website and available on request, thereby fully appreciating the manner in which Bestmed may process our Personal Information and for which purpose(s) Bestmed may process such Personal Information.

   3.2 That through submitting this application as a corporate member/participating employer, we may be providing Bestmed with the Personal Information and/or Special Personal Information of our employees and their spouse(s), children and or other dependant third parties.

   3.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by us from time to time.

   3.4 That Bestmed may from time to time, depending on the circumstances, collect our Personal Information, as well as that of our employees and their spouse(s), children and or other dependant third parties from another source other than directly from us.

   3.5 That we fully appreciate that Bestmed places a high premium on our privacy, as well as the privacy of our employees, their spouse(s), children and or other dependant third parties.

   3.6 That we 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 our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties shall be processed with a reasonable standard of care as may be expected from Bestmed.

   3.7 That we fully appreciate that Bestmed will only process our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.

   3.8 That, in accordance with the provisions of Section 18 of POPIA, we have been provided with adequate notification of the processing of our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties by Bestmed, the scope and purpose(s) for such processing, as well as our rights to object to such processing should we elect to do so.

   3.9 That we acknowledge that the processing of our Personal Information is a mandatory requirement for the existence of a valid medical insurance agreement and for us to enjoy the status of a corporate member/participating employer.

4. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, we hereby provide our specific and informed consent to Bestmed for the processing of our Personal Information, for any purpose(s) legitimately connected or related to our application for corporate membership and/or membership as a participating employer, which purpose(s) may include, but not be limited to the following:

   4.1 To provide or manage any information, products and/or services requested by us pursuant to our application for membership.

   4.2 To establish our needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.

   4.3 To facilitate the delivery of products and/or services to us as a corporate member/participating employer of Bestmed.

   4.4 To administer any claims and premiums pertaining to us.

   4.5 To activate any policies or prescribed benefits pursuant to our membership.

   4.6 To allocate a unique identifier to us for the purpose of securely storing, retaining, and recalling our Personal Information from time to time, including after our corporate membership or membership as a participating employer is terminated.

   4.7 For general administration purposes pertaining to our membership.

   4.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards us.

   4.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals and pharmacies to facilitate the delivery of products and/or services to us.

   4.10 To provide us with health and wellness information throughout the subsistence of our membership.

   4.11 To transact with third parties and transfer our Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards us.

   4.12 To analyse our Personal Information collected for research and statistical purposes.

   4.13 To transfer our Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.

   4.14 To carry out analysis and profiling of our membership profile.

   4.15 To identify other products and services which might be of interest to us, as well as to inform us of such products and/or services.

   4.16 To obtain and share information about our credit worthiness with any credit bureau or credit provider's industry association or industry body, which includes information pertaining to our credit history, financial history, judgements, default history and sharing information for purposes of risk analysis, tracing and related purposes.

5. In as far as we provide Bestmed with the Personal Information of any third party, including the Personal Information of our employees, their spouse(s), children or other dependants, we hereby warrant that we have acquired the consent of such third party to do so and that we are a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

   The representative acting on our behalf herein and facilitating the submission of this application to Bestmed, warrants that he/she is duly authorised to act on our behalf and to thereby bind us to the terms and conditions related to this application.

Signature of employer

HR practitioner details

Surname

Full names

E-mail

Telephone number

State that the applicant

a. Has been **permanently** employed by us since D D M M Y Y Y Y

b. Bestmed membership to start D D M M Y Y Y Y

c. Department

d. Employee number

e. Total monthly contribution to be paid to Bestmed R .

Remarks

Signature of HR practitioner

Date D D M M Y Y Y Y

Name stamp of employer