PERMISSION TO CHANGE BANKING DETAILS - MEMBER

FORM TO CHANGE BANKING DETAILS

What you must do

Please go through these two steps:

Step 1: Fill in the form from **step 1-5**.

Step 2: Sign the application at **step 6 and 7**.

How to complete this form

- To avoid administration delays, please make sure this form is completed in full.
- Once completed, please fax your form to 012 472 6500 or e-mail to membership@bestmed.co.za

Your banking details will only be changed if:

1. The information on this form matches the information on Bestmed's records at the moment.
2. This form has been signed by the principal member as well as the account holder, if different.

NOTE : PLEASE ATTACH THE FOLLOWING

NOTE: Proof of bank account not older than 3 months must be attached hereto for verification purposes

1. BANK DETAILS TO BE CHANGED

Contributions	Claims	All

2. PRINCIPAL MEMBER'S DETAILS

Membership number

ID number

Tel (W)

Cell

Tel (H)

E-mail

I,

(Name & surname) as principal member give Bestmed permission to change my banking details.

3. PREVIOUS ACCOUNT DETAILS

Account holder

Bank

Branch name

Branch code

Account number

Type of account | Cheque | Savings |

4. NEW ACCOUNT DETAILS

Effective date for change D D M M Y Y Y Y

* Debit order deduction date 20th 25th 1st

Account holder name

Bank

Branch

Branch code

Type of account Cheque/current Savings

Account number

Select account holder Member Company *Other

Name of company
(Complete only if selected above)

***If you have selected "OTHER" please complete below section in accordance with SARS legislative requirements where account holder differs from the principal member:**

Title

Contact number

First name

Middle name

Initials

Surname

E-mail

Account holder ID number

Passport number (for non-SA citizens)

Country of issue

SARS tax number

Date of birth D D M M Y Y Y Y

Home address

Postal code

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

Postal address (Domicilium citandi et executandi)

Postal code

CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details
If you selected NO, please complete your claims refund banking details below Yes No

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 ID number/passport number for non-SA citizens

Account holder ID number

I/we hereby authorise Bestmed to draw against my/our account with the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account), the contribution amount for the selected benefit option on the above mentioned date or the first working day thereafter. I/we further authorise Bestmed to adjust the amount due as contributions are amended from time to time. All such withdrawals from my/our account by Bestmed shall be treated as though they have been signed by me/us personally. I/we agree to pay bank charges relating to this debit order instruction. This authority may be cancelled by me/us by giving Bestmed one month's notice in writing via e-mail, fax or registered post, starting on the first day of the following calendar month. Should there be a breach of this contract there is a possibility that the member will be held responsible for payments incurred. I/we understand that I/we shall not be entitled to any refunds of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Bestmed. I/we acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorised party. The deduction of debit order will take place in the month before inception date should you choose the 20th or 25th as the debit order date subject to subscriptions payable in advance.

5. RELATIONSHIP OF ACCOUNT HOLDER TO MAIN MEMBER

Relationship to principal member

6. SIGNATURE

Signed at

Date D D M M Y Y Y Y

Signature of principal member

Signature of account holder

7. CONSENT PROVISIONS BY PRINCIPAL MEMBER

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