Please fax completed applications to 021 7978856 or email it to enquiries@classmed.co.za

ESKOM APPLICATION FORM

bestMed

1. APPLICANT (PRINCIPAL MEMBER)

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

First name

Middle name | Initials

Surname

ID number | Gender M F | Preferred language Eng Afr

Passport number

Country of issue (passport) | Date of birth D D M M Y Y Y Y

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		Pulse1 * ‡	
Beat2		Beat2N (Network) †		Pace2		Pulse2 ‡	
Beat3		Beat3N (Network) †		Pace3			
Beat4				Pace4			

Income bracket if you are joining on the Pulse1 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.

†

Take note: If any of the BeatN options are selected, please initial next to the acknowledgements below. Due to the efficiency discount imposed on the BeatN options, I acknowledge and agree to the following:	Initial
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: If any of the Pulse options are selected, please initial next to the acknowledgements below. Due to the contracted designated service provider network pertaining to the Pulse options, I acknowledge and agree that my chosen unique benefit option is subject to the following:	Initial
1. Primary care service provider network	
2. Specialist network	
3. Hospital network	

Initial of applicant:

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/s) R .

2. Total monthly medical savings account R .

3. Extended family (including monthly savings) R .

MONTHLY TOTAL (1-3) R .

Healthcare advisor name: Deon Valentine

Healthcare advisor code: CMAI01G0KNSS

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

Cell phone 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

1. Dependant details

First name

Surname

ID number (passport number for non-SA citizens)

Gender: M | F

Country of issue (passport)

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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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 (passport)

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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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 (passport)

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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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 (passport)

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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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 (passport)

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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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 (passport) 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 ☐ Partner/fiancé/common law spouse *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other *(please specifiy relationship below)* ☐

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

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 on this day of month Y Y Y Y

Signature of principal member

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 on this day of month Y Y Y Y

Signature of principal member

* 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.

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

Initial of applicant:

11. MEDICAL QUESTIONNAIRE

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.*

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 the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Date diagnosed	Last treatment date	Level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation
1. Congenital physical deviations e.g. bat ears, valvular heart disease	Yes	No				
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis, acne	Yes	No				
3. Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems	Yes	No				
4. Sensory organs: sight, hearing, speech, also state spectacles and/or contact lenses	Yes	No				
5. Respiratory system e.g. asthma, COPD	Yes	No				
6. Cardio-vascular systems e.g. hypertension, high cholesterol, heart failure, thrombosis	Yes	No				
7. Digestive system e.g. hiatus hernia, stomach ulcer, spastic colon, gallstones	Yes	No				
8. Urinary system, e.g. kidney problems (infections, failure, dialysis, stones) or bladder problems (infection, incontinence)	Yes	No				
9. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems	Yes	No				
10. Psychiatric or psychological treatment e.g. depression, anxiety, sleeping disorders, counselling	Yes	No				
11. Nervous system e.g. paralysis, epilepsy, Parkinson's disease, headaches, stroke	Yes	No				
12. Substance dependence e.g. alcohol, drugs, rehabilitation	Yes	No				
13. Have you ever been diagnosed with cancer, a growth or tumour of any kind? Please state type and date.	Yes	No				
14. Dental treatment	Yes	No				
15. Ear, Nose and throat related treatment, e.g. grommets, nasal surgery, tonsils	Yes	No				

Initial of applicant:

16. Operations undergone. Please state type and date.	Yes	No				
17. Current medication used, not yet stated above	Yes	No				
18. 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.

19. 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				
20. Any other medical condition not mentioned above, that you or your dependant(s) might have received treatment or advice, or consult a doctor for, in the past 12 months?	Yes	No				
21. For males only						
21a. Male reproductive system, e.g. prostate and testes problems	Yes	No				
21b. Hormone system e.g. hormone replacement therapy	Yes	No				
22. For females only						
22a. Pregnancy or suspected pregnancy	Yes	No				
22b. Female reproductive system, e.g. endometriosis, menstrual problems and infertility	Yes	No				

Please note: If you are currently using chronic medicine, also complete the separate chronic application form available on the website, or call 086 000 2378. If patient was registered for chronic medication at the previous medical scheme, please submit a copy of the previous chronic authorisation letter.

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.

I,

(principal member name and surname) declare 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

Initial of applicant:

12. PREVIOUS MEMBERSHIP STATUS

Please supply previous membership certificates, from a South African registered medical scheme, as relevant proof of previous medical aid cover. This 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

13. THE FOLLOWING DOCUMENTS/INFORMATION ARE COMPULSORY

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

1. If a child is older than 21, 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 21 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 the Bestmed Pulse1 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, level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation).
   - Signed and dated.
8. Upon completing an affidavit, ensure full details are disclosed e.g. day, month, year, names of previous schemes.

14. 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. 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);

c. 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;

d. 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;

e. 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;

f. 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;

g. 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.

h. 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.

i. I hereby consent to my personal information and that of my dependants being processed by Bestmed for a variety of purposes, which may include, but is not limited to the following purposes:
   - to carry out analysis and member profiling, such as to determine medical risk;
   - to transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals and pharmacies to facilitate the delivery of services to members;
   - to provide health and wellness information and/or services to members;
   - to help detect and prevent fraud and money laundering;
   - where Bestmed has a legal duty to process information to any relevant regulatory authorities, where appropriate measures have been specified for protecting the legitimate interest of the member.

j. I hereby affirm that I am aware that the processing of my personal health information is a mandatory requirement for the existence of a valid medical insurance agreement between the parties and that I am aware of my right to object to the processing and/or further processing of my personal information and of my right to lodge a complaint to the information regulator.

Signature of applicant

Signature of witness

Signed at

on this day of month Y Y Y Y

Initial of applicant:

15. STATEMENT BY EMPLOYER

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

Employer name

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. Unique number

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

Remarks

Signature of HR practitioner

Name stamp of employer

Date D D M M Y Y Y Y