

**1. APPLICANT (PRINCIPAL MEMBER)**

Title	<input type="text"/>	Date of change	<input type="text"/>							
First name	<input type="text"/>									
Middle name	<input type="text"/>						Initials	<input type="text"/>		
Surname	<input type="text"/>									
ID number	<input type="text"/>								Gender	<input type="text"/>
Home language	<input type="text"/>									
Passport number	<input type="text"/>									
Membership number	<input type="text"/>					Date of birth	<input type="text"/>			
Marital status	<input type="text"/>	Date of marriage/ divorce	<input type="text"/>							
Current employer	<input type="text"/>									
Date of employment	<input type="text"/>	Employee number	<input type="text"/>							

**2. DEPENDANTS TO BE ADDED****1. Dependant details**

First name	<input type="text"/>																
Surname	<input type="text"/>																
ID number (passport number for non-SA citizens)	<input type="text"/>							Gender	<input type="text"/>								
Country of issue	<input type="text"/>						Date of birth	<input type="text"/>									
SARS tax number	<input type="text"/>																
Dependant contact number	<input type="text"/>																
Email address	<input type="text"/>																

**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')

<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Partner/fiancé/common law spouse (complete declaration in section 8)	<input type="checkbox"/>	Child (if difference in surname, complete declaration in section 9)	<input type="checkbox"/>	Other
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**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

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

**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

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

**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

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

**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

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

**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

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

**If other, please specify relationship:**

(affidavit/legal documents and proof of income required) \_\_\_\_\_

## 3. ELIGIBILITY OF DEPENDANT(S)

\* The rules of the Scheme will determine admission and the applicable rates.

<b>Children are regarded as such only up to the age of 21, unless studying (but not older than 26).</b>		
1. Is your child older than 21 and currently studying? Proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant. Please ensure student proof is attached for the current year of study? (Student cards will not be accepted.)	Yes	No
2. Are the adult dependant(s) financially dependent on the principal member?  Do the dependant(s) receive an income, e.g. pension, salary? Provide <b>proof of income per dependant</b> (3 months' payslips or bank statements - not older than 3 months).	Yes	No
	Yes	No
If yes, what is the monthly income?		
Dependant 1 <input type="text"/>	Dependant 3 <input type="text"/>	
Dependant 2 <input type="text"/>	Dependant 4 <input type="text"/>	



## 7. 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
	Yes	No				
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				

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](mailto: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 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				

**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, infertility and hormone replacement therapy	Yes	No				

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

Yes	No
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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 authorization 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](http://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																			
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(principal member name and surname) acknowledge that all information declared above is true and correct.

Signed by me 

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 on this 

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 day of 

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 month 

Y	Y	Y	Y
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Signature of principal member

Initial of applicant:	
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## 8. 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", attach the membership certificate(s) of the previous scheme(s), confirming the start and end date of membership

Name of scheme	Member number	Principal member	Dependant	Date from	Date to

## 9. UNDERWRITING THAT MIGHT APPLY

**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 principle 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:

- 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.
- 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

## 10. APPLICATION AND DECLARATION

I herewith apply for:

Recognition of my abovementioned dependants as beneficiary(ies) of the Scheme on the grounds that, to the best of my knowledge:

1. The details in respect of your dependant(s) set out above are true and correct and that they qualify for enrolment as dependant(s) in terms of the Scheme Rules;

2. My aforementioned children are fully dependent on me, or, if they have an income, the income does not exceed the maximum basic social pension per year; and

3. My aforementioned dependants are in good health, both mentally and physically. Should an applicant be unable to sign the declaration as required in (1) and (2) on account of temporary absence of a dependant or on account of ill health or of a mental or physical disability of such a dependant, full details should be submitted to the Scheme for consideration.

I undertake on behalf of the above mentioned dependant(s) to abide by the Rules of the Scheme.

Signed by me

on this



day of






Signature of principal member

\* The rules of the Scheme will determine admission and the applicable rates.

## 11. STATEMENT BY EMPLOYER

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

Employer name

Employee number

### HR practitioner details

Surname

Full names

E-mail

Telephone number

Remarks

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Signature of HR practitioner

Date










Name stamp of employer