

# INDIVIDUAL APPLICATION FORM

## 1. APPLICANT (PRINCIPAL MEMBER)

Title	<input type="text"/>	Bestmed join date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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"/>						Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home language	<input type="text"/>													
Passport number	<input type="text"/>								Gender	<input type="text"/>	<input type="text"/>			
Country of issue	<input type="text"/>													
SARS tax number (mandatory)	<input type="text"/>													
Marital status	<input type="text"/>	<input type="text"/>	Date of marriage/divorce	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Current employer	<input type="text"/>													
Date of employment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Employee number	<input type="text"/>					

## 2. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	<input type="checkbox"/>	Beat1N (Network) †	<input type="checkbox"/>	Pace1	<input type="checkbox"/>	Rhythm1 * ‡	<input type="checkbox"/>
Beat2	<input type="checkbox"/>	Beat2N (Network) †	<input type="checkbox"/>	Pace2	<input type="checkbox"/>	Rhythm2 * ‡	<input type="checkbox"/>
Beat3	<input type="checkbox"/>	Beat3N (Network) †	<input type="checkbox"/>	Pace3	<input type="checkbox"/>		
Beat3 Plus	<input type="checkbox"/>			Pace4	<input type="checkbox"/>		
Beat4	<input type="checkbox"/>						

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
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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
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\* Provide **proof of income** (3 months' payslips or bank statements - not older than 3 months). Please note that you will be registered on the highest bracket, pending proof of income.

† **Members on any of the BeatN options enjoy an efficiency discount. 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.

‡ **Members on a Rhythm option are restricted to the contracted Rhythm designated service provider network. By selecting a Rhythm option you acknowledge and agree that your option is subject to the following:**

1. GP network
2. Specialist network (Referral required from network GP)
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.
9. I am aware of the submission cut-off date for new registrations.

### 4. SUMMARY OF MONTHLY COST

Failure to complete the below section in full will result in unsuccessful broker commission payments

**TOTAL MONTHLY PREMIUM**


R										
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Healthcare advisor name

S	h	a	m	i	e	m	A	h	m	e	d								
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Healthcare advisor code

1	2	6	8	0														
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Healthcare advisor signature

Date

D	D	M	M	Y	Y	Y	Y
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### 5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

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Telephone number (w)

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Fax number

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Telephone number (h)

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Cellphone number

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Is your physical address the same as your postal address?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**Physical address**

Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Street

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Suburb

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Town/city

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Postal code

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**Postal address details (Domicilium citandi et executandi)**

Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Street

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Suburb

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Town/city

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Postal code

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Please download the Bestmed App for access to your digital membership card on date of registration, and look out for an SMS with a link after registration has been completed.

## 6. YOUR BANKING DETAILS

### DEBIT ORDER FOR MONTHLY CONTRIBUTIONS BANKING DETAILS

For monthly contributions, please complete your debit order deduction banking details below

* Debit order deduction date	20 <sup>th</sup>	25 <sup>th</sup>	1 <sup>st</sup>
Bank			
Branch			
Branch code		Type of account	Cheque/current Savings
Account number			
Select account holder	Member	Company*	Other*

\*If you have selected "COMPANY" or "OTHER" please complete the sections below, including the address section. This is in accordance with SARS legislative requirements.

#### COMPANY

Registered name of company	
Type of company (e.g. private)	
Entity registration number	

#### OTHER

Title	
First name	
Middle name	
Surname	
Account holder ID number	
Passport number (for non-SA citizens)	
Country of issue	
SARS tax number (mandatory)	Date of birth
	D D M M Y Y Y Y
Physical address <small>(mandatory field for both "COMPANY" and "OTHER")</small>	
	Postal code
Is your physical address the same as your postal address?	Yes No
Postal address <small>(Domicilium citandi et executandi)</small>	
	Postal code

#### CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details?

Yes	No
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If you selected "NO", please complete your claims refund banking details below

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 email, 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.

Signature of principal member

Signature of account holder

**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

SARS tax number

Dependant contact number

Email address

**The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.**

**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)

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**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

**The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.**

**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)

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**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

**The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.**

**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) \_\_\_\_\_

**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

**The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.**

**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) \_\_\_\_\_

**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

**The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.**

**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) \_\_\_\_\_

6. Dependant details

First name, Surname, ID number (passport number for non-SA citizens), Gender (M/F), Country of issue, Date of birth (D/M/Y/Y), SARS tax number, Dependant contact number, Email address

The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.

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)

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

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 Scheme Rules 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:

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

## 11. PREVIOUS MEMBERSHIP STATUS

**Please supply ALL previous membership certificates, from a South African registered medical scheme for you and your dependants, 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. In the event that you are unable to obtain previous membership certificate(s), Bestmed will accept an affidavit if previous cover exceeds 5 years. Visit [www.bestmed.co.za](http://www.bestmed.co.za) to complete affidavit in the relevant blocks. Please refer to applicant checklist (section 14) of this form for more details.**

Have you and/or your spouse/partner and/or dependant(s) been a member or dependant of a medical scheme?

Yes	No
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I was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months with no break in membership between previous medical scheme and Bestmed, contributions at my previous scheme were paid in arrears therefore I would like to continue to pay Bestmed in arrears.

Yes	No
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**According to the Medical Scheme's Act a member/dependant may not belong to 2 medical schemes at the same time therefore it is imperative that we receive a certificate with a resign date to continue with the registration process.**

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 This section is extremely important:

**Please complete the following questionnaire** to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders, irrespective of it being chronic or acute and no matter how insignificant it may seem. **If the answer is YES, please give full details of the person and condition concerned in the space provided.** If the space provided is insufficient, provide the details on a separate page and attach it to this questionnaire, medical reports may be included. **The examples listed under each condition below are not intended as a full list of conditions, disorders or symptoms, but only serve as examples. In other words, the examples below are only a limited list and do not include all possible conditions. Please note that all fields are compulsory.**

Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? <b>Please clearly specify the diagnosed conditions in relevant tables.</b>	Indicate with an "X" (compulsory)		Name of patient	Specify illness/condition/disorder in full	Date of first diagnosis or problem	Latest consultation/test/treatments with dates	Please state ALL medicines: name and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms, dates of last symptoms experienced
1. Infectious diseases e.g. hepatitis B, tuberculosis, tetanus, bilharzia, etc.	Yes	No					
2. Positive for HIV/AIDS*	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.							
3. Cancer diagnosis/treatment, or a growth or tumour of any kind? Please state type - benign or malignant.	Yes	No					
4. Blood conditions: e.g. anaemia, blood clotting problems, deep vein thrombosis, pulmonary embolism, platelet deficiencies, haemophilia, leukaemia, lymphoma, bleeding disorders.	Yes	No					
5. Endocrine and metabolic conditions : e.g. obesity, diabetes mellitus, porphyria, thyroid problems, Cushing syndrome, metabolic syndrome, Addison disease, any other endocrine or metabolic conditions	Yes	No					
6. Psychiatric conditions: e.g. depression, anxiety, bipolar disorder, autism, Asperger syndrome, sleeping disorders (e.g. narcolepsy), insomnia, eating disorders, drug or alcohol use disorder or rehabilitation, suicide attempt, post-traumatic stress disorder, counselling, recent psychological trauma.	Yes	No					
7. Brain and nervous system or neuromuscular conditions: e.g. paralysis, epilepsy, Parkinson disease, headaches, stroke, cerebral palsy, paraplegia, hemiplegia, carpal tunnel syndrome, chronic headache, migraine, multiple sclerosis, motor neuron disease, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability.	Yes	No					
8. Eye and eyelid conditions: e.g. vision problems, blurry vision, glasses, cataracts, keratoconus, corneal ulcers, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, corneal transplant, eye surgery, partial or full blindness, astigmatism, any other eye or eyelid condition.	Yes	No					
9. Ear, nose and throat problems: e.g. grommets, otitis media, tinnitus, ear infections, deafness, hearing problems, use of hearing aids, cochlear implant, tonsillitis or adenoiditis, dizziness, vertigo, previous sinus or nasal surgery, sinusitis, deviated nasal septum, allergic rhinitis, chronic blocked nose or sinuses.	Yes	No					



10. Heart and circulation problems: e.g. high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins.	Yes	No					
11. Lung and breathing problems: e.g. asthma, COPD/emphysema, bronchitis, bronchiolitis, pulmonary embolism, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia.	Yes	No					
12. Digestive and gastrointestinal problems: e.g. hiatus/abdominal/inguinal hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, hepatitis, cirrhosis, portal hypertension, alcohol or fatty liver disease, liver failure, pancreatitis, cystic fibrosis, Crohn disease, ulcerative colitis, diverticulitis, jaundice.	Yes	No					
13. Skin condition (including allergies): e.g. eczema, psoriasis, acne, chronic wounds, melanoma, skin cancer, sunspots, warts, skin tags, mole irritation or shape and colour change.	Yes	No					
14. Dental, oral, and maxillofacial consultation and/or treatment: e.g. dental fillings, orthodontics, crowns, dentures, implants, temporomandibular joint disorders, jaw surgery, cleft lip or palate, etc.	Yes	No					
15. Skeletal, joint and muscle deviations/problems: e.g. neck/back/knee/hip problems/pain, arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus (SLE), gout, clubfoot, bunions, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, etc.	Yes	No					
16. Kidney and urinary conditions: e.g. kidney failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, etc.	Yes	No					
17. Male reproductive system: e.g. prostate cancer, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, vasectomy, circumcision, erectile dysfunction, etc.	Yes	No					
18. Pregnancy or suspected pregnancy? If yes, please confirm gestation/duration of pregnancy. Are you currently undergoing treatment towards getting pregnant? Provide date of Last Normal Menstruation (LNM).	Yes	No					
19. Female reproductive system: e.g. endometriosis, menstrual problems or irregularities, infertility, hormone replacement therapy, sterilisation/hysterectomy, abnormal Pap smear result, polycystic ovarian syndrome, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, etc.	Yes	No					
20. Congenital deviations: e.g. bat ears, cleft palate, patent ductus arteriosus (PDA), heart defects, Down Syndrome, neural tube defects, spina bifida, brain defects, ventricular septum defect (VSD), etc.	Yes	No					
21. Rare disorders/conditions: e.g. congenital disorders of glycosylation, Hunter syndrome, lysosomal storage diseases, Klinefelter syndrome, etc.	Yes	No					



### 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
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Signature of applicant

