Please email completed applications to enquiries@classmed.co.za

ESKOM APPLICATION FORM (WINDOW PERIOD)

1. APPLICANT (PRINCIPAL MEMBER)

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

Full name as per ID document

First name

Middle name | Initials

Surname

ID number / refugee number | Date of birth D D M M Y Y Y Y

Passport number (for non-SA citizens) | Gender M F

Country of issue

SARS tax number (mandatory)

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
Beat2	Beat2N (Network) †	Pace2
Beat3	Beat3N (Network) †	Pace3
Beat3 Plus		Pace4
Beat4		

Rhythm1 * ‡

Rhythm2 * ‡

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 monthly

* 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

© Bestmed Medical Scheme
Bestmed Medical Scheme is an Authorised Financial Services Provider (FSP no. 44058)

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. By accessing personal information as a broker, including but not limited to the applicant (member) and/or dependant personal information, I acknowledge and agree that I will be complying with the Protection of Personal Information Act 4 of 2013 ("POPIA") and any other applicable data protection law in respect of all personal information, including implementing appropriate security safeguards and responding to any data subject request directed to me.
3. 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.
4. I confirm that the applicant was given my personal details, including my physical and postal address, and contact number.
5. 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.
6. 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.
7. I declare that the applicant is familiar with the information required in the application form and he/she has provided all the correct information.
8. I declare that the advice and support given to the applicant was unbiased and in his/her best interest.
9. I declare that the applicant has personally signed this application form.
10. I am aware of the submission cut-off date for new member registrations.

4. SUMMARY OF MONTHLY COST

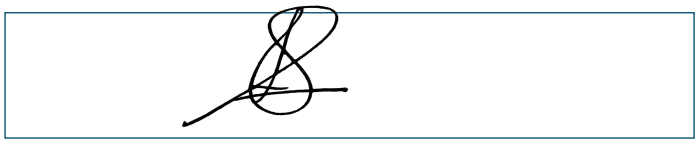
Failure to complete the below section in full will result in unsuccessful broker commission payments

TOTAL MONTHLY PREMIUM R . .

Healthcare advisor name (mandatory) Shamiem Ahmed

Healthcare advisor code (mandatory) 126800

(Healthcare advisor name and code are mandatory for commission payments)



Healthcare advisor signature

Date D D M M Y Y Y Y

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Your email address is essential for correspondence.
If possible, please provide your personal email address instead of your work email address.

Telephone number (w)

Cell phone number

Telephone number (h)

Physical address

Address

Street

Suburb

Town / city

Postal code

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

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 ID number / passport number for non-SA citizens

Account holder ID number

Signature of applicant

Signature of account holder (if different from applicant)

7. DEPENDANTS TO BE ADDED

1. Dependant details

First name

Middle name

Surname

ID number / refugee 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

Physical address

Postal code

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 ☐ Child ☐ Other

If other, please specify relationship:
(affidavit / legal documents required)

Declaration for this specific dependant - *select if applicable*

☐ **Partner / fiancé / common-law spouse with a different surname:** I, the principal member, declare that I am in a sustained, committed and serious relationship akin to marriage with this dependant, based on objective criteria of mutual dependency and a shared household.

☐ **Child with a different surname:** I declare that this child is my biological child / my partner or spouse's biological child.

☐ **Dependant aged 24 years or older (applicable to child / sibling / grandchild):** I acknowledge and understand that adult dependant contributions apply and agree to pay the applicable contribution in accordance with the Scheme's terms and conditions. I further confirm that he/she is financially dependent on me.

2. Dependant details

First name

Middle name

Surname

ID number / refugee 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

Physical address

Postal code

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.

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If other, please specify relationship:
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3. Dependant details

First name

Middle name

Surname

ID number / refugee 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

Physical address

Postal code

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If other, please specify relationship:
(affidavit / legal documents required)

Declaration for this specific dependant - *select if applicable*

☐ **Partner / fiancé / common-law spouse with a different surname:** I, the principal member, declare that I am in a sustained, committed and serious relationship akin to marriage with this dependant, based on objective criteria of mutual dependency and a shared household.

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☐ **Dependant aged 24 years or older (applicable to child / sibling / grandchild):** I acknowledge and understand that adult dependant contributions apply and agree to pay the applicable contribution in accordance with the Scheme's terms and conditions. I further confirm that he/she is financially dependent on me.

4. Dependant details

First name

Middle name

Surname

ID number / refugee 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

Physical address

Postal code

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 ☐ Child ☐ Other

If other, please specify relationship:
(affidavit / legal documents required)

Declaration for this specific dependant - *select if applicable*

☐ **Partner / fiancé / common-law spouse with a different surname:** I, the principal member, declare that I am in a sustained, committed and serious relationship akin to marriage with this dependant, based on objective criteria of mutual dependency and a shared household.

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5. Dependant details

First name

Middle name

Surname

ID number / refugee 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

Physical address

Postal code

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 ☐ Child ☐ Other

If other, please specify relationship:
(affidavit / legal documents required)

Declaration for this specific dependant - *select if applicable*

☐ **Partner / fiancé / common-law spouse with a different surname:** I, the principal member, declare that I am in a sustained, committed and serious relationship akin to marriage with this dependant, based on objective criteria of mutual dependency and a shared household.

☐ **Child with a different surname:** I declare that this child is my biological child / my partner or spouse's biological child.

☐ **Dependant aged 24 years or older (applicable to child / sibling / grandchild):** I acknowledge and understand that adult dependant contributions apply and agree to pay the applicable contribution in accordance with the Scheme's terms and conditions. I further confirm that he/she is financially dependent on me.

8. POPIA PROVISIONS FOR APPLICANT

Personal Information Processing Notice: Membership Administration and Scheme Purposes

Bestmed Medical Scheme is required to process personal information, including special personal information such as health information, in order to assess, conclude, continue, administer and manage your membership and the membership of your registered dependants.

This notice explains why Bestmed collects and uses personal information, the lawful grounds relied on, and where further information can be found.

1. Information we process

Bestmed may process personal information relating to you, your spouse, partner, children and other dependants, including: personal and contact details; identity, passport, tax and demographic information; banking and payment information; employment and income information where relevant to your selected benefit option; dependant and family relationship information; previous medical scheme membership information; claims, benefits, treatment, authorisation and healthcare provider information; medical history, diagnosis, medication, disability, pregnancy, HIV/AIDS and other health-related information where required for underwriting, claims, benefits, managed care and Scheme administration; and communications with you, your dependants, healthcare providers, brokers, administrators and service providers.

2. Why we process the information

Bestmed processes this information for lawful Scheme purposes, including to: assess and process your application for membership or continuation of membership; verify identity, eligibility and dependant status; determine and administer the applicable benefit option, contributions, waiting periods, late-joiner penalties and underwriting requirements; administer debit orders, refunds and contribution payments; assess, authorise and pay claims and benefits; manage chronic, prescribed minimum benefit, managed care and other benefit processes; communicate with you and, where appropriate, your adult dependants; comply with the Medical Schemes Act, tax, financial, regulatory, audit and record-keeping obligations; prevent, detect and investigate fraud, non-disclosure, abuse or irregular claims; obtain or share information with healthcare providers, administrators, managed care providers, brokers, contracted service providers, banks, regulators and other persons where necessary for Scheme purposes; conduct reporting, analytics, actuarial, risk, quality assurance, research and statistical activities using appropriate safeguards; and enforce or defend Bestmed's rights and obligations.

3. Lawful basis for processing

Bestmed does not rely on consent as the sole basis for processing personal information required for membership.

Depending on the purpose, Bestmed processes personal information where processing is necessary to take steps relating to your application or to perform and administer the membership relationship; to comply with obligations imposed by law; to protect your or your dependants' legitimate interests, including access to healthcare funding and benefits; and to pursue Bestmed's legitimate interests or those of relevant third parties, including Scheme administration, claims management, fraud prevention, risk management and regulatory compliance.

Where the Protection of Personal Information Act 4 of 2013 ("POPIA"), or another law, requires consent or authorisation for a specific activity, Bestmed will request it separately or include it clearly in the relevant form.

Where you have appointed, or continue to be represented by, a broker who is accredited and registered to render broker services in relation to your membership ("your Broker"), Bestmed and your Broker each act as separate responsible parties in relation to your personal information and that of your registered dependants, as contemplated in POPIA. Your Broker does not process your personal information on Bestmed's behalf, under Bestmed's instruction, or as Bestmed's operator; your Broker processes it in order to perform the mandate you have given your Broker and to comply with your Broker's own obligations under the Financial Advisory and Intermediary Services Act 37 of 2002, the Medical Schemes Act 131 of 1998, and other applicable laws governing broker services. Bestmed processes and discloses your personal information to your Broker in order to perform Bestmed's own obligations to you as a member of the Scheme, and to enable your Broker to perform its obligations to you as your appointed intermediary.

4. Mandatory information

The information requested in this form is generally mandatory where it is required to assess, conclude, continue or administer membership, register dependants, determine contributions and benefits, apply underwriting rules, process claims, comply with legal obligations, or protect the Scheme against non-disclosure, fraud or abuse.

Failure to provide required information, or providing incomplete or inaccurate information, may result in Bestmed being unable to process the application, register a dependant, administer benefits, assess claims, apply the correct underwriting terms, pay refunds, comply with legal obligations, or continue membership.

5. Information about dependants and other persons

Where you provide information about your spouse, partner, child or other dependant, you confirm that you are authorised to provide that information for Scheme membership purposes. Where the dependant is a child, you confirm that you are a competent person for purposes of POPIA, where applicable.

Bestmed may communicate directly with adult dependants about their own personal information and benefits where appropriate and in line with POPIA, Scheme Rules and applicable law.

6. Sources of information

Bestmed may collect personal information directly from you or from other lawful sources where necessary for Scheme purposes. These sources may include your dependants, healthcare providers, hospitals, pharmacies, previous medical schemes, brokers, employers where applicable, administrators, managed care providers, banks, regulators, fraud-prevention bodies and other service providers.

7. Sharing of information

7.1 Bestmed may share personal information with persons and organisations where necessary for the purposes described in this notice. These may include administrators, managed care providers, healthcare providers, hospitals, pharmacies, banks, payment service providers, IT and data service providers, auditors, professional advisers, regulators, statutory bodies, law enforcement authorities, fraud-prevention bodies, your Broker, and other contracted operators or service providers.

7.2 Bestmed requires operators and service providers who process personal information on its behalf to protect the information and process it only for authorised purposes.

7.3 Your Broker is not an operator or service provider of Bestmed. Where you have appointed a broker, Bestmed and your Broker each process your personal information as separate responsible parties, and Bestmed shares your personal information with your Broker where necessary for your Broker to perform its mandate and for Bestmed to perform its obligations to you, as further described in Bestmed's Data Protection and Privacy Policy.

7.4 In order to give effect to your Broker's mandate, Bestmed may disclose the following categories of your personal information, and that of your registered dependants, to your Broker:

- Biographical information, including membership number, ID number, date of birth, postal and residential address, email address and contact numbers;
- Benefit information, including benefit option, available benefits, limits applicable to your benefit option, status of authorisations and waiting period information;
- Financial information, including monthly subscription, balance due or outstanding, available medical savings account balance, membership certificate and tax certificate; and
- Medical information, including chronic or prescribed minimum benefit conditions, claim transaction history, medication used, and medical procedures performed, including procedure codes.

7.5 By appointing, retaining or continuing to be represented by a broker in connection with your membership, you acknowledge and accept that: (a) it is necessary for Bestmed to disclose your personal information, and that of your registered dependants, to your Broker to the extent described above, in order for your Broker to perform its mandate and for Bestmed to perform its obligations to you as a member; (b) Bestmed does not rely on your consent as the sole basis for this disclosure, and processes and discloses such personal information where necessary to perform its obligations to you, to protect your legitimate interests as a member, and in pursuit of the legitimate interests of Bestmed and of your Broker, as contemplated in sections 11(1)(b), (d) and (f) of POPIA; (c) you or your Broker may terminate the broker's appointment at any time by written notice to Bestmed, following which Bestmed will not disclose further personal information to that broker, save to the extent still required by law or to complete a transaction already in progress; and (d) Bestmed will not be liable to you for any loss you may suffer arising from a disclosure of personal information to your Broker made in accordance with this clause, save to the extent that such loss arises from Bestmed's own negligence, willful misconduct, or a breach by Bestmed of its obligations under POPIA.

8. Cross-border processing

Bestmed may transfer or store personal information outside South Africa where this is necessary for Scheme administration, technology, support, service delivery, reporting or other lawful purposes. Where this occurs, Bestmed will take reasonable steps to ensure that the information receives appropriate protection as required by POPIA.

9. Retention

Bestmed will retain personal information for as long as reasonably required for the purposes for which it was collected, including membership administration, claims and benefits management, legal, regulatory, tax, audit, dispute-resolution, fraud-prevention and record-keeping purposes.

10. Privacy Policy and data subject rights

Further details about how Bestmed processes personal information, protects information, retains records, handles cross-border transfers and gives effect to data subject rights are available in Bestmed's Data Protection and Privacy Policy, available on Bestmed's website or on request.

You have rights under POPIA, including the right to request access to your personal information, request correction or deletion where applicable, object to processing in appropriate circumstances, and lodge a complaint with the Information Regulator.

11. Optional marketing and wellness communications

Bestmed may send you legally required communications and important membership, benefit, contribution, claims, tax, Scheme Rules, service and health-related information. These communications form part of Scheme administration and are not optional marketing.

Bestmed may also send you optional marketing or promotional communications about Bestmed products, services, wellness initiatives, newsletters or additional benefit information, where permitted by law.

Please indicate your preference:

☐ Yes, I agree to receive optional marketing and promotional communications from Bestmed.

☐ No, I do not agree to receive optional marketing and promotional communications from Bestmed.

You may change your marketing preference or opt out of optional marketing communications at any time. Opting out of optional marketing will not affect mandatory membership, benefit, claims, legal or Scheme administration communications.

12. Applicant acknowledgement

By signing this form, I acknowledge that I have been notified of the processing of personal information by Bestmed for the purposes described above and in Bestmed's Data Protection and Privacy Policy. I understand that the processing of required personal information is necessary for Bestmed to assess, conclude, continue, administer and manage membership and related Scheme purposes.

D	D	M	M	Y	Y	Y	Y

Signature of applicant

9. STATEMENT OF APPLICANT

I, _____

hereby declare that by signing and submitting this application form, I agree to the terms and conditions of Bestmeds membership registration and adhere to the rules and regulations of Bestmed Medical Scheme.

To be completed by Member

Signature of applicant

Signed at _____ on this _____ day of _____ month Y Y Y Y

10. STATEMENT BY EMPLOYER

Personal Information Processing Notice: Corporate Membership and Participating Employer
Bestmed Medical Scheme processes personal information relating to a corporate member / participating employer, and requires the employer to provide personal information relating to its employees and their registered dependants, in order to establish, register, continue, administer and manage corporate membership and to give effect to individual membership and dependant registration under this application.

This notice explains why Bestmed collects and uses personal information in the corporate membership context, the lawful grounds relied on, and where further information can be found.

1. **Information we process**

   Bestmed may process personal information relating to the employer, including corporate, contact, HR, banking and billing information, and personal information relating to the employer's employees and their spouses, partners, children and other dependants provided in connection with this application, including identity, contact, employment, benefit option and contribution information.

2. **Why we process the information**

   Bestmed processes this information for lawful Scheme purposes, including to assess and conclude the corporate membership / participating employer relationship; register employees and their dependants as members and dependants of the Scheme; determine and administer benefit options, contributions, billing and premiums; communicate with the employer, its HR and payroll representatives, and members regarding the corporate account; comply with the Medical Schemes Act, tax, financial, regulatory, audit and record-keeping obligations; and prevent, detect and investigate fraud, non-disclosure or irregular activity.

3. **Lawful basis for processing**

   Bestmed does not rely on consent as the sole basis for processing personal information required to establish and administer corporate membership. Depending on the purpose, Bestmed processes personal information where necessary to conclude and perform the corporate membership agreement; to comply with obligations imposed by law; and to pursue Bestmed's legitimate interests, or those of the employer or its employees, in the proper administration of corporate membership. Where POPIA or another law requires consent for a specific activity, Bestmed will request it separately or include it clearly in the relevant form.

4. **Employer's warranty regarding employee and dependant information**

   Where the employer provides Bestmed with the personal information of its employees, or of employees' spouses, children or other dependants, the employer warrants that it has lawful authority to disclose that information to Bestmed for the purposes described in this notice and in Bestmed's Data Protection and Privacy Policy, and that it is a "competent person" as contemplated in POPIA in respect of any such third-party information, where applicable. The employer remains responsible for taking reasonable steps to inform its employees that their personal information is being provided to Bestmed for these purposes.

5. **Mandatory information**

   The information requested in this application is generally mandatory where it is required to assess, conclude and administer corporate membership and to register employees and dependants. Failure to provide required information may result in Bestmed being unable to process the application or administer the corporate membership.

6. **Sharing, cross-border processing and retention**

   Bestmed may share personal information with administrators, managed care providers, banks and payment service providers, auditors, regulators and other contracted service providers where necessary for the purposes described above, and may transfer or store information outside South Africa where necessary for Scheme administration, subject in each case to appropriate safeguards. Bestmed will retain personal information for as long as reasonably required for the purposes described above and for legal, regulatory and record-keeping purposes.

7. **Privacy Policy and rights**

   Further details, including the employer's and data subjects' rights under POPIA, are available in Bestmed's Data Protection and Privacy Policy, available on Bestmed's website or on request.

8. **Employer acknowledgement**

   By signing this form, the employer acknowledges that it has been notified of the processing of personal information described above and in Bestmed's Data Protection and Privacy Policy, and the representative signing on the employer's behalf warrants that they are duly authorised to do so and to bind the employer to this application.

Employer name

D	D	M	M	Y	Y	Y	Y

Signature of employer

11. HR PRACTITIONER DETAILS

Surname

Full names

Email

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

Name stamp of employer

Date D D M M Y Y Y Y