INDIVIDUAL APPLICATION FORM
INDIVIDUELE AANSOEKVORM

bestMed

1. APPLICANT (PRINCIPAL MEMBER) / AANSOEKER (HOOFLID)

Title
Titel

Date of inception
Aanvangsdatum D D M M Y Y Y Y

Surname
Van

Full names
Volle name

Date of birth of principal member
Geboortedatum van hooflid D D M M Y Y Y Y

Language preference
Taalvoorkeur Eng Afr

Marital status
Huwelikstatus Unmarried Married

Date of marriage
Datum van huwelik D D M M Y Y Y Y

ID number/Passport number
ID-nommer/Paspoortnommer

Gender
Geslag M F

Current employer
Huidige werkgewer

Period employed
Tydperk in diens

2. BENEFIT OPTION / VOORDEELOPSIE

Benefit option (indicate with 'X') / Voordeelopsie (dui aan met 'X')

Beat1		Beat1N (Network) †		Pace1		Pulse1 * ‡	
Beat2		Beat2N (Network) †		Pace2		Pulse2 ‡	
Beat3		Beat3N (Network) †		Pace3 *			
Beat4				Pace4			

* Provide **proof of income** (3 months' payslips or bank statements - not older than 3 months) for the Pace3 and Pulse1 options. Please note that you will be registered on the highest interval, pending proof of income.
* Voorsien **bewys van inkomste** (3 maande se betaalstrokies of bankstate - nie ouer as 3 maande nie) vir die Pace3 en Pulse1 opsies. Let wel dat u op die hoogste interval geregistreer sal word, tot en met bewys van inkomste ontvang word.

†

Take note: If any of the BeatN options is 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: Let wel: Indien enige van die BeatN opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die doeltreffendheidsafslag wat op die BeatN opsies van toepassing is, neem ek kennis en stem toe tot die volgende:	Initial Parafeer
1. I am limited to a hospital network as determined by the Scheme. 1. Ek is beperk tot 'n hospitaalnetwerk soos deur die Skema bepaal.	
2. I am aware of the location of the nearest above-mentioned network hospital providers. 2. Ek is bewus van die naaste bovermelde hospitaal netwerkverskaffers se ligging.	
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 (as set out in the brochure). 3. As ek uit vrye keuse nie van die voormelde netwerkverskaffers gebruik maak nie, is ek bewus daarvan en stem ek toe dat ek verantwoordelik gehou sal word vir 'n bybetaling in gevolge die Skemareëls (soos in die brosjure bepaal).	
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. 4. Ek is bewus dat hierdie 'n unieke voordeelopsie is en dat ek nie gedurende die jaar van 'n BeatN-opsie na 'n standaard Beat-opsie, in gevolge van die Skemareëls, mag skuif nie.	

‡

Take note: If any of the Pulse options is 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: Let wel: Indien enige Pulse opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die gekontrakteerde aangewese diensverskaffersnetwerk wat betrekking het tot die Pulse opsies, neem ek kennis en stem toe dat my gekose unieke voordeelopsie onderhewig is aan die volgende:	Initial Parafeer
1. Primary care service provider network 1. Primêresorg diensverskaffersnetwerk	
2. Specialist network 2. Spesialisnetwerk	
3. Hospital network 3. Hospitaalnetwerk	

Initial of applicant:
Paraaf van aansoeker:

3. DEPENDANTS / AFHANKLIKES

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)	Relationship* Verwantskap*
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		

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

* Die Skemareëls sal die toelating en die toepaslike tariewe bepaal.

4. THE FOLLOWING DOCUMENTS ARE COMPULSORY / DIE VOLGENDE DOKUMENTE IS 'N VEREISTE

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 or a statement if the child is older than 21 and unemployed.		As 'n kind ouer as 21 is, word 'n bewys van registrasie by 'n tersiêre instelling (tot op 'n ouderdom van 26) verlang om as 'n kinderafhanklike te kwalifiseer, of 'n verklaring indien die kind ouer as 21 en werkloos is.
In the case of extended family (parent, brother or sister only) - affidavit of dependant(s) with regards to dependency on principal member.		In die geval van uitgebreide familie (slegs ouer, broer of suster) - beëdigde verklaring van afhanklike(s) met betrekking tot afhanklikheid van hooflid.
Proof of previous medical scheme membership must be provided; this applies to members and all dependants (NB: Not a membership card). The aforesaid proof must contain the period and type of cover.		Bewys van lidmaatskap van vorige mediese skemas; dit geld vir lede sowel as alle afhanklikes (LW: Nie 'n lidmaatskapkaart nie). Die bogenoemde bewys moet die soort en tydperk van dekking insluit.
In the case of a handicapped child dependant, a report from a medical practitioner.		In die geval van 'n gestremde kinderafhanklike, 'n verslag van 'n mediese praktisyn.
In the case of registering a life partner as a dependant, a declaration with regards to shared household responsibility.		In die geval waar 'n lewensmaat geregistreer word as afhanklike, 'n verklaring met betrekking tot gemeenskaplike huishoudelike verantwoordelikheid.

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER) / ADRES EN KONTAKBESONDERHEDE (HOOFLID)

Residential address
Woonadres

Code
Kode

(Domicilium citandi et executandi)

Postal address
(If different from residential)
Posadres
(Indien anders as woonadres)

Code
Kode

Please take note that all future hard-copy correspondence will be sent to the postal address provided above.
Let wel dat alle toekomstige hardekopie korrespondensie gestuur sal word na die posadres soos bo verskaf.

Tel (W)

Tel (H)

Cell numbers:
Selfoonnommers:

Fax
Faks

Principal member
Hooflid

Dependant
Afhanklike
Name
Naam

Dependant
Afhanklike
Name
Naam

Dependant
Afhanklike
Name
Naam

E-mail
E-pos

Total member cards required
Aantal lidmaatskapkaarte benodig

Until receiving your membership card/s via post, you are able to download your e-card via the Bestmed App.
Tot tyd en wyl u lidmaatskap kaart/e u bereik, kan u gerus u e-kaart aflaai via die Bestmed App.

Initial of applicant:
Paraaf van aansoeker:

6. PREVIOUS MEMBERSHIP STATUS / VORIGE LIDMAATSKAPSTATUS

Have you and/or your spouse/partner and/or dependant(s) been a member(s) or dependant(s) of a medical scheme(s)?
Was u en/of u gade/metgesel en/of afhanklike(s) 'n lid/afhanklike van 'n mediese skema(s)?

Yes/Ja	No/Nee

If "yes" attach termination certificate
Indien "ja" heg beëindigingsertifikaat aan

Name of scheme Naam van skema	Member number Lidmaatskapnommer	Principal member Hooflid	Dependant Afhanklike	Date from Datum vanaf	Date to Datum tot

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.

Late Joiner Penalty (in terms of Regulation 131 of the Medical Schemes Act (Act 131 of 1998))

Late joiner penalties can be imposed on new members over the age of 35. Depending on the number of years the member did not belong to a medical scheme, a late joiner penalty will be added to the member's monthly 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 member did not belong to a medical scheme.

Laataansluitingsboete (in gevolge Regulasie 131 van die Wet op Mediese Skemas (Wet 131 van 1998))

Laataansluitingsboetes kan op nuwe lede wat ouer as 35 jaar is gehef word. Afhangende van die aantal jare waartydens die lid nie aan 'n mediese skema behoort het nie, sal 'n laataansluitingsboete by die maandelikse bydrae gevoeg word. Die boete word bereken op 'n glyskaal soos uiteengesit in die onderstaande tabel en word gebaseer op die totale aantal jare ná die ouderdom van 35 effektief 1 April 2001, waartydens die lid nie aan 'n mediese skema behoort het nie.

Number of years since age 35 where applicant was not a member of a medical scheme Aantal jare sedert ouderdom 35 waartydens die aansoeker nie 'n lid van 'n mediese skema was nie	Penalty Boete
1 - 4 years/jaar	0.05 x contribution / bydrae
5 - 14 years/jaar	0.25 x contribution / bydrae
15 - 24 years/jaar	0.50 x contribution / bydrae
25+ years/jaar	0.75 x contribution / bydrae

Initial of applicant:
Paraaf van aansoeker:

8. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

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.

Let wel: In die geval van 'n JA, moet die volle besonderhede van die betrokke persoon voorsien word in die beskikbare spasie. Indien u of enige van u afhanklikes aan 'n chroniese siektetoestand lei, word 'n mediese verslag benodig wat die besonderhede uiteensit. Indien die spasie wat voorsien word nie voldoende is nie, verskaf asseblief besonderhede op 'n afsonderlike bladsy en heg dit by hierdie vraelys aan.

Have you or any of your proposed beneficiary(-ies) received any medical advice, diagnosis, care or was treatment recommended or received for the following within the 12-month period ending on the date on which you are applying for membership? Het u of u voorgestelde begunstigde(s) in die laaste 12 maande voor hierdie aansoek om lidmaatskap enige mediese behandeling of sorg, of advies rakende enige van die volgende toestande ontvang?	Indicate with an "X" (compulsory) Dui aan met 'n "X" (verpligtend)		Name of patient Naam van pasiënt	Date diagnosed Datum gediagnoseer	Level/stage of illness, condition, nature of treatment, medication, dosage and hospitalisation Graad/stadium van toestand, aard van behandeling, medikasie, dosis en hospitalisasie
1. Congenital physical deviations e.g. bat-ears, valvular heart disease Kongenitale fisiese afwykings bv. bakore, hartklepsiektes	Yes / Ja	No / Nee			
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis Velabnormaliteit (insluitende allergieë) bv. ekseem, psoriase	Yes / Ja	No / Nee			
3. Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems Skelet-, gewrigs- en spierafwykings en probleme bv. artritis, rugprobleme	Yes / Ja	No / Nee			
4. Sensory organs: sight, hearing, speech, also state spectacles and/or contact lenses Sintuie: sig, gehoor, spraak, meld brille en/of kontaklense	Yes / Ja	No / Nee			
5. Respiratory system e.g. asthma, COPD Siektes van die lugweë bv. asma, KOLS	Yes / Ja	No / Nee			
6. Cardio-vascular systems e.g. hypertension, cholesterol Siektes van die kardiovaskulêre stelsel bv. hipertensie, cholesterol	Yes / Ja	No / Nee			
7. Digestive system e.g. hiatus hernia, stomach ulcer Spysverteringstelselsiektes bv. hiatus hernia, maagseer	Yes / Ja	No / Nee			
8. Urinary system, e.g. kidney problems (infections, failure, dialysis, stones) or bladder problems (infection, incontinence) Urienwegsisteem, bv. nierprobleme (infeksies, versaking, dialise en stene) of blaasprobleme (infeksie, inkontinensie)	Yes / Ja	No / Nee			
9. Male reproductive system, e.g. prostate and testes problems Manlike reproduktiewe sisteem, bv. prostaat- en testesprobleme	Yes / Ja	No / Nee			
10. Female reproductive system, e.g. endometriosis, menstrual problems and infertility Vroulike reproduktiewe sisteem, bv. endometriose, menstruele probleme en onvrugbaarheid	Yes / Ja	No / Nee			
11. Hormone system e.g. hormone replacement therapy Hormoonstelsel bv. hormoonvervangingsterapie	Yes / Ja	No / Nee			
12. Pregnant or suspected pregnancy Swanger of vermoede van swangerskap	Yes / Ja	No / Nee			
13. Nervous system e.g. paralysis, epilepsy, Parkinson's disease Senuweestelselsiektes bv. verlamming, epilepsie, Parkinsonse siekte	Yes / Ja	No / Nee			
14. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems Metaboliese siektes bv. vetsug, diabetes, porfirie, skildklierprobleme	Yes / Ja	No / Nee			

15. Psychiatric or psychological treatment e.g. depression, anxiety Psigiatriese of sielkundige behandeling bv. depressie, angs	Yes / Ja	No / Nee			
16. Substance dependence e.g. alcohol, drugs Middelafhanklikheid bv. alkohol, dwelms	Yes / Ja	No / Nee			
17. Have you ever been diagnosed with cancer? Please state type and date. Is kanker ooit voorheen by u gediagnoseer? Spesifiseer tipe en datum.	Yes / Ja	No / Nee			
18. Operations undergone. Please state type and date. Operasies ondergaan. Spesifiseer tipe en datum.	Yes / Ja	No / Nee			
19. Are you and/or your dependant(s) currently being treated for a medical condition or symptoms not stipulated above? Word u en/of u afhanklike(s) tans vir 'n mediese toestand of simptome behandel wat nie bo vermeld word nie?	Yes / Ja	No / Nee			
20. 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 'n Toestand waarvoor u en/of u afhanklike(s) 'n uitbetaling en/of gewaarborgde mediese behandeling van welke aard ookal ontvang het, bv. derdeparty eis	Yes / Ja	No / Nee			
21. Current medication used Huidige medisyne wat gebruik word	Yes / Ja	No / Nee			
22. Dental treatment Tandheelkundige behandeling	Yes / Ja	No / Nee			
23. Contagious diseases e.g. positive for HIV/AIDS, Hepatitis B, Tuberculosis Oordraagbare / aansteeklike siektes bv. positief vir MIV/VIGS, Hepatitis B, Tuberkulose 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. Indien u en/of enige van u afhanklikes MIV-positief is, of VIGS het en verkies om nie u en/of hul MIV-status op hierdie vorm te meld nie, weens vertroulikheid, moet u 012 472 6249 skakel of 'n e-pos stuur na mhc@bestmed.co.za om Bestmed in kennis te stel van u en/of u afhanklike(s) dat u en/of u afhanklikes met MIV/Vigs saamleef. Hierdie inligting moet binne sewe (7) werksdae vanaf die datum van u aansoek vir u en/of u afhanklike(s) se lidmaatskap aan Bestmed gemeld word. By ontvangs van die versoek sal Bestmed bepaal of onderskrywingstoestande toegepas sal word, en indien dit die geval is, sal u 'n dokument met 'n gewysigde bewys van lidmaatskap ontvang.	Yes / Ja	No / Nee			
24. Any other medical condition not mentioned above, even though you or your dependant(s) did not receive treatment or advice, or consult a doctor in the past 12 months? Enige ander mediese aangeleentheid wat nie hierbo gemeld is nie, selfs al het u of u afhanklike(s) nie behandeling of advies ontvang, of 'n dokter gekonsulteer in die laaste 12 maande nie?	Yes / Ja	No / Nee			

Please note: if you are currently using chronic medication, also complete the separate application form available on the website, or call 086 000 2378
Let wel: indien u tans chroniese medisyne gebruik, voltooi ook die afsonderlike aansoekvorm wat beskikbaar is op die webwerf, of skakel 086 000 2378

Initial of applicant:
Paraaf van aansoeker:

9. HEALTHCARE ADVISOR DECLARATION / GESONDHEIDSORGADVISEUR SE VERKLARING

1) I declare that I am an accredited Bestmed healthcare advisor, I am fully licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Healthcare Advisor Services Act 37 of 2002 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.

1) Ek verklaar dat ek 'n geakkrediteerde Bestmed gesondheidsorgadviseur is, ten volle gelisensieer is deur die Raad op Finansiële Dienste (RFD) in gevolge die Wet op Finansiële Advies- en Gesondheidsorgadviesdienste 37 van 2002 en 'n geakkrediteerde makelaar ingevolge Wet 65 van die Wet op Mediese Skemas is.

2) Ek aanvaar dat die aansoeker my aangestel het as sy/haar gesondheidsorgadviseur en dat hy/sy daarop geregtig is om my dienste te beëindig.

3) Ek bevestig dat die aansoeker my persoonlike besonderhede, insluitend my fisiese en posadres, sowel as my telefoonnommer ontvang het.

4) Ek verklaar dat ingevolge Wet 131 van 1998 van die Wet op Mediese Skemas (of soos gewysig), 'n maandelikse statutêre kommissie aan my uitbetaal sal word, tot en met 'n maksimum bedrag soos vasgestel deur die Wet op Mediese Skemas.

5) Ek erken dat daar geen wanvoorstelling van enige feite deur my is nie en dat in die geval van materiële of onwettige optrede, ek verantwoordelik sal wees vir die terugbetaling van alle gelde wat betaal is in die effek van so 'n wanvoorstelling.

6) Ek verklaar dat die aansoeker bekend is met die inligting wat benodig word in die aansoekvorm en dat hy/sy al die korrekte inligting verskaf het.

7) Ek verklaar dat die raad en ondersteuning wat gegee is aan die aansoeker onbevooroordeeld en in sy/haar beste belang is.

8) Ek verklaar dat die aansoeker persoonlik hierdie aansoekvorm onderteken het.

10. SUMMARY OF MONTHLY COST / OPSOMMING VAN MAANDELIKSE KOSTES

1. Total high risk premium (principal member or principal member and spouse/partner and child dependant/s)
Totale hoë-risiko premie (hooflid of hooflid en gade/metgesel en kinderafhanklike(s)

R | | | | | | | | . | | |

2. Total monthly medical savings account
Totale maandelikse mediese spaarrekening

R | | | | | | | | . | | |

3. Extended family (including monthly savings)
Uitgebreide familie (ingesluit maandelikse spaarrekening)

R | | | | | | | | . | | |

MONTHLY TOTAL (1-3)
TOTALE MAANDELIKSE KOSTE (1-3)

R | | | | | | | | . | | |

Healthcare advisor name
Naam van gesondheidsorgadviseur: Carla Haskins - Compendium Insurance Brokers

Healthcare advisor code
Gesondheidsorgadviseurskode

Healthcare advisor signature/Handtekening van gesondheidsorg-adviseur

Datum
Date: D D M M Y Y Y Y

Initial of applicant:
Paraaf van aansoeker:

11. YOUR BANKING DETAILS / U BANKBESONDERHEDE

ID number of principal member
ID-nommer van hooflid

Account holder
Rekeninghouer

Bank
Bank

Branch code
Takkode

Please circle the relevant blocks and print **YOUR ACCOUNT NUMBER** in the **last row**
Omsirkel asseblief die betrokke blokkies en skryf u **REKENINGNOMMER** in die **laaste ry**

0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

Type of account
Rekening tipe

Cheque
Tjek

Savings
Spaar

* Day of debit order
* Dag van debietorder

20th/20ste | 25th/25ste | 1st/1ste

*** Or the first working day thereafter/Of die eerste werksdag daarna**

If you do not want to use the same banking details for your contributions and claims refunds, please provide the details for claims reimbursements below:
Indien u verkies om nie dieselfde bankbesonderhede te gebruik vir bydraes en eisbetalings nie, verskaf asseblief die besonderhede vir eisbetalings onder:

Account holder
Rekeninghouer

Bank
Bank

Branch code
Takkode

Please circle the relevant blocks and print **YOUR ACCOUNT NUMBER** in the **last row**
Omsirkel asseblief die betrokke blokkies en skryf u **REKENINGNOMMER** in die **laaste ry**

0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

Type of account
Rekening tipe

Cheque
Tjek

Savings
Spaar

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

Ek/ons magtig hiermee Bestmed om geld te onttrek uit my/ons rekening by die bogenoemde bank (of enige bank of tak waarna ek/ons my/ons rekening oorplaas) ten bydrae van die **onderstaande bedrag** op die bogemelde datum of die eerste werksdag daarna. Ek/ons bemagtig Bestmed verder om die bedrag aan te pas soos wat die ledegelde van tyd tot tyd verander. Alle sodanige onttrekkings van my/ons rekening sal geag word asof deur my/ons persoonlike geteken. Ek/ons onderneem om bankkostes gekoppel aan hierdie debietorder te betaal. Ek/ons mag hierdie magtiging kanselleer deur Bestmed een maand skriftelik via e-pos, faks of geregistreerde pos in kennis te stel, vanaf die eerste dag van die opvolgende kalendermaand. Indien daar kontrakbreuk sou wees, bestaan die moontlikheid dat die lid aanspreeklik gehou sal word vir kostes aangegaan. Indien bydrae wettiglik verskuldig was aan Bestmed, verstaan ek/ons dat ek/ons nie geregtig sal wees op enige terug betaling van bydrae wat onttrek is terwyl hierdie magtiging van krag was nie. Ek/ons bevestig dat die onttrekking teen my/ons rekening nie deur die gemagtigde party gesedeer mag word en dat die gemagtigde party nie enige van sy regte mag oordra na 'n derde party sonder my/ons vooraf skriftelike toestemming nie en dat ek/ons nie enige verpligtinge ingevolge hierdie kontrak/magtiging aan enige derde party delegeer sonder vooraf skriftelike toestemming van die derde party nie. Ledegeld is vooruit betaalbaar en word in die maand voor registrasie gevorder indien die 20ste of 25ste gekies word as die debietorder datum.

MONTHLY TOTAL
TOTALE MAANDELIKSE KOSTE

R							.		

Signature of principal member/Handtekening van hooflid

Signature of account holder/ Handtekening van rekeninghouer

12. STATEMENT OF APPLICANT / VERKLARING DEUR AANSOEKER

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 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, 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 any 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 or declare the membership null and void in which case all monies paid to Bestmed in connection with this membership before Bestmed is informed of the change, shall be forfeited and benefits paid by Bestmed shall immediately be refunded to Bestmed;

h. Bestmed reserves the right to cancel membership should it become apparent that false information was wilfully supplied on this application.

i. 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.

j. I hereby consent to my personal health information being processed by Bestmed for the purpose of determining my medical risk profile and to my information being further processed by any managed healthcare partner, loyalty benefits partners or any separate entities that provide health-related services independently, or on behalf of Bestmed, for inter alia the purpose of:

- selecting beneficial wellness programme options on behalf of the members;
- allowing agents of such managed healthcare partners, loyalty benefits administrators or independent entities to determine the optimal products and services to be offered to Bestmed members;
- offering said options, products and services to members with their prior consent.

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.

Ek, _____

_____ verklaar dat:

a. Indien ek as lid van Bestmed ingeskryf word, ek my aan die reëls van Bestmed sal onderwerp;

b. Die inligting hierin na die beste van my wete en oortuiging volkome waar is en dat ek geen inligting verswyg het nie. Ek aanvaar dat die mediese spaarrekening pro rata bereken word (waar van toepassing);

c. Ek verstaan dat indien my aansoek om lidmaatskap goedgekeur en aanvaar word, die inligting vervat in my aansoekvorm in die toekoms die basis sal vorm van my aansoek en die betaling van voordele;

d. Ek gee onherroeplik toestemming aan enige geneesheer, persoon of instansie wat in besit mag wees of in besit mag kom van inligting aangaande my gesondheid of dié van my afhanklike(s), om die inligting aan Bestmed of sy gevolmagtigde te openbaar, ook na my dood of dié van my afhanklike(s). Ek verstaan dat die inligting tesame met ander inligting in ag geneem sal word met die evaluasie van betalings ten opsigte van sekere mediese toestande. Ek waarborg dat ek my afhanklike(s) se toestemming verkry het om hierdie magtiging te verleen;

e. Ek onderneem om my bydrae op rekeninge aan Bestmed te vereffen en by versuim magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my salaris af te trek, of indien ek sou bedank, magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my pensioen of enige ander gelde aan my betaalbaar af te trek en aan Bestmed oor te betaal;

f. Indien daar na my toelating as lid van Bestmed gevind word dat enige verklaring of inligting deur my verstrek, willens en/of wetens onvoldoende of onwaar was, ek toestem om alle betalings wat Bestmed namens my gemaak het, ten volle terug te betaal en om alle aanspreeklikheid op enige voordele aan die kant van Bestmed, te verbeur;

g. Enige verswakking of verandering in my gesondheidstoestand of in dié van my afhanklikes voor die datum of gebeurtenis wat deur Bestmed vir die aanvang van lidmaatskap gestel sal word, of die datum van die aanvaarding van hierdie aansoek deur Bestmed, of die datum van ontvangs van die eerste ledegelde, watter een ookal laaste is, Bestmed die reg sal gee om die aansoek te heroorweeg en nuwe voorwaardes vir toelating voor te stel of die lidmaatskap nietig te verklaar, in welke geval alle gelde wat ten opsigte van hierdie lidmaatskap aan Bestmed betaal is voordat Bestmed kennis van die verandering ontvang het, verbeur word en uitbetaalde voordele onverwyld aan Bestmed terugbetaal sal word;

h. Bestmed behou die reg om lidmaatskap onverwyld te kanselleer indien dit aan die lig sou kom dat valse inligting willens en wetens met hierdie aansoek verskaf is.

i. Ek is bewus daarvan dat die datum van my aansoek nie noodwendig verwys na die datum van my toelating as 'n Bestmed-lidmaat nie en dat die toelatingsdatum so spoedig moontlik deur Bestmed aan my gekommunikeer sal word.

j. Ek gee hiermee toestemming dat my persoonlike gesondheidsinligting deur Bestmed verwerk mag word met die doel om my mediese risikoprofiel te bepaal en dat my inligting verder verwerk mag word deur enige bestuurdesorgvennoot, loyaliteitsprogramvennoot of enige afsonderlike entiteit wat gesondheidsverwante dienste onafhanklik aanbied, of namens Bestmed inter alia vir die doel om:

- voordelige gesondheidsorgprogramme namens die lede te verkies;
- sodat agente van sodanige gesondheidsorgprogramme, administrateurs van lojaliteitsvoordele of onafhanklike entiteite die optimale dienste en produkte mag bepaal wat aangebied gaan word aan Bestmed-lede;
- dat die bogemelde opsies, produkte en dienste aangebied mag word aan die lede wat hul toestemming vooraf daarvoor gegee het.

Ek bevestig hiermee dat ek daarvan bewus is dat die verwerking van my persoonlike gesondheidsinligting 'n verpligte vereiste vir die bestaan van 'n geldige mediese versekeringsooreenkoms tussen die partye is, en dat ek bewus is van my reg om teen die verwerking en/of verdere verwerking van my persoonlike inligting beswaar te mag maak, en op my reg om 'n formele klag te mag lê by die inligtingsreguleerder.

_____ _____

Signature of applicant/Handtekening van aansoeker | Signature of witness/Handtekening van getuie

Signed at / Geteken te _____ on the / op die _____ day of / dag van _____ 20__