CORPORATE MEMBER CONTINUATION FORM
(No payer broker appointment)

1. REASON FOR CHANGE

☐ Change due to continuation as a pensioner — Change effective from D D M M Y Y Y Y

☐ Principal member deceased, dependant continuation (widow, widower or orphan) — Change effective from D D M M Y Y Y Y
Please attach death certificate

2. DETAILS OF CURRENT PRINCIPAL MEMBER

Membership number

Initials — SARS tax number (SARS legislative requirement)

Surname

Previous employer

Employee number

3. DETAILS OF APPLICANT (NEW PRINCIPAL MEMBER)

Title — Full names

Surname

ID number — Date of birth D D M M Y Y Y Y

Home language

Passport number

Country of issue (passport)

SARS tax number (SARS legislative requirement)

Tel number — Cell number

Physical address

Code

E-mail address

4. BENEFIT OPTION

Option change subject to mandate and relevant approval. Please refer to Bestmed Scheme Rules

New benefit option (indicate with 'X')

Beat1		Beat1N (Network) †		Pace1		Rhythm1 * ‡	
Beat2		Beat2N (Network) †		Pace2		Rhythm2 * ‡	
Beat3		Beat3N (Network) †		Pace3			
Beat3 Plus				Pace4			
Beat4							

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 - R 8 500 monthly	R 8 501 and above 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. Primary care service provider network
2. Specialist network
3. Hospital network

5. 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	20th	25th	1st

Bank

Branch

Branch code

Type of account: Cheque/current | Savings

Account number

Select account holder: Member | Company | *Other

Name of company
(Complete only if selected above)

***If you have selected "OTHER" please complete below section in accordance with SARS legislative requirements where account holder differs from the principal member:**

Title

First name

Middle name

Initials

Surname

Account holder ID number

Passport number (for non-SA citizens)

Country of issue

SARS tax number | | | | | | | | | | |

Date of birth | D | D | M | M | Y | Y | Y | Y |

Home address

																Postal code						

Is your home address the same as your postal address? | Yes | No |

Postal address (Domicilium citandi et executandi)

																Postal code						

CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details
If you selected NO, please complete your claims refund banking details below | Yes | No |

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 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. 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

6. CALCULATION OF MONTHLY CONTRIBUTION

This section should only be completed if your change is subject to approval from your Human Resources department

1. Employer subsidy per month — R . .

2. Member's monthly contribution — R . .

TOTAL MONTHLY CONTRIBUTION (1-2) — R . .

Employer name

Date D D M M Y Y Y Y

Approval from Human Resources department — Yes / No

EMPLOYER APPROVAL

Name

Surname

Tel number

Signature of employer

Date D D M M Y Y Y Y

7. STATEMENT BY EMPLOYER

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

We (employer name)

1. Hereby warrant that, in as far as we provide Bestmed with any Personal Information and/or Special Personal Information ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA), pertaining to our employees, their dependants, spouse(s) and/or children, we do so with the express informed consent of such employee.

2. We hereby confirm that in as far as we provide Bestmed with the Personal Information of any Third Party as contemplated in clause 1 above, we do so in our capacity as "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

3. We hereby expressly make the following acknowledgements in respect of Bestmed's processing of our Personal Information ("referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):

   3.1 That we have considered and fully understand the provisions of the Data Protection and Privacy Policy published on Bestmed's website and available on request, thereby fully appreciating the manner in which Bestmed may process our Personal Information and for which purpose(s) Bestmed may process such Personal Information.

   3.2 That through submitting this application as a corporate member/participating employer, we may be providing Bestmed with the Personal Information and/or Special Personal Information of our employees and their spouse(s), children and or other dependant third parties.

   3.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by us from time to time.

   3.4 That Bestmed may from time to time, depending on the circumstances, collect our Personal Information, as well as that of our employees and their spouse(s), children and or other dependant third parties from another source other than directly from us.

   3.5 That we fully appreciate that Bestmed places a high premium on our privacy, as well as the privacy of our employees, their spouse(s), children and or other dependant third parties.

   3.6 That we 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 our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties shall be processed with a reasonable standard of care as may be expected from Bestmed.

   3.7 That we fully appreciate that Bestmed will only process our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.

   3.8 That, in accordance with the provisions of Section 18 of POPIA, we have been provided with adequate notification of the processing of our Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties by Bestmed, the scope and purpose(s) for such processing, as well as our rights to object to such processing should we elect to do so.

   3.9 That we acknowledge that the processing of our Personal Information is a mandatory requirement for the existence of a valid medical insurance agreement and for us to enjoy the status of a corporate member/participating employer.

4. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, we hereby provide our specific and informed consent to Bestmed for the processing of our Personal Information, for any purpose(s) legitimately connected or related to our application for corporate membership and/or membership as a participating employer, which purpose(s) may include, but not be limited to the following:

   4.1 To provide or manage any information, products and/or services requested by us pursuant to our application for membership.

   4.2 To establish our needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.

   4.3 To facilitate the delivery of products and/or services to us as a corporate member/participating employer of Bestmed.

   4.4 To administer any claims and premiums pertaining to us.

4.5 To activate any policies or prescribed benefits pursuant to our membership.

4.6 To allocate a unique identifier to us for the purpose of securely storing, retaining, and recalling our Personal Information from time to time, including after our corporate membership or membership as a participating employer is terminated.

4.7 For general administration purposes pertaining to our membership.

4.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards us.

4.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals and pharmacies to facilitate the delivery of products and/or services to us.

4.10 To provide us with health and wellness information throughout the subsistence of our membership.

4.11 To transact with third parties and transfer our Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards us.

4.12 To analyse our Personal Information collected for research and statistical purposes.

4.13 To transfer our Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.

4.14 To carry out analysis and profiling of our membership profile.

4.15 To identify other products and services which might be of interest to us, as well as to inform us of such products and/or services.

4.16 To obtain and share information about our credit worthiness with any credit bureau or credit provider's industry association or industry body, which includes information pertaining to our credit history, financial history, judgements, default history and sharing information for purposes of risk analysis, tracing and related purposes.

5. In as far as we provide Bestmed with the Personal Information of any third party, including the Personal Information of our employees, their spouse(s), children or other dependants, we hereby warrant that we have acquired the consent of such third party to do so and that we are a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

   The representative acting on our behalf herein and facilitating the submission of this application to Bestmed, warrants that he/she is duly authorised to act on our behalf and to thereby bind us to the terms and conditions related to this application.

Signature of employer

8. APPLICATION AND DECLARATION

I herewith apply for:
1. Change due to continuation as a pensioner
2. Change due to principal member deceased, dependant continuation (widow, widower or orphan)
I acknowledge that I, as well as my existing dependant(s) shall be bound by the rules of the Scheme as amended from time to time. I the undersigned, hereby apply to be admitted as the principal member of the membership profile and hereby agree to the rules of the Scheme. **By signing this form, I agree to the terms and conditions of Bestmed's membership and confirm that I have fully read and understood each of the pages included in this form.**

Signed by me

Signature of principal member

Date

D	D	M	M	Y	Y	Y	Y

* The Scheme Rules will determine admission and the applicable rates.

9. 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

Signature of applicant