INDIVIDUAL MEMBER CONTINUATION FORM

bestMed

1. REASON FOR CHANGE

☐ Change from corporate to individual membership — Change effective from D D M M Y Y Y Y

☐ Individual principal member deceased, dependant continuation — Change effective from D D M M Y Y Y Y

Please attach death certificate

☐ Dependant transfer to main member (main member swap) — Change effective from D D M M Y Y Y Y

Only applicable if current main member remains as a dependant
Please provide a reason for the principal member swap:

Note: For principal member swop, both the original and new principal member must sign the form in the applicable sections.

2. DETAILS OF ORIGINAL PRINCIPAL MEMBER

Membership number

Initials — SARS tax number (SARS legislative requirement)

Surname

Current option

Previous employer

Signature of original principal member

Date D D M M Y Y Y Y

3. DETAILS OF APPLICANT (NEW PRINCIPAL MEMBER) - THIS SECTION IS COMPULSORY

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

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. GP network
2. Specialist network (Referral required from network GP)
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*

***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
(mandatory field for both "COMPANY" and "OTHER")

Postal code

Is your physical 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

ACCOUNT HOLDER CONTACT DETAILS

Tel number

Cell number

Postal address

Postal code

Email address

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

6. BROKER CONFIRMATION

In terms of the Financial Accounting Information System (FAIS) Act, please select the appropriate option

☐ I want to continue with my current brokerage/broker.

☐ I want to appoint a new brokerage/broker on my Bestmed membership profile. Please complete section 7 of the Bestmed continuation form.

☐ I want to remove my current broker. I will deal with Bestmed in my own capacity.

7. NEW BROKER DETAILS

Brokerage name

Brokerage code

Broker name

Broker code

DECLARATION

I

am duly authorised to appoint the intermediary mentioned in the above, to act as agent on our/my behalf for the purpose of all our/my dealings with Bestmed Medical Scheme. Furthermore, I request that all information pertaining to my medical scheme in respect of myself and my dependants be released to (please specify brokerage/broker)

and indemnify my selected brokerage/broker as well as Bestmed Medical Scheme against any claims or damages suffered as a result of disclosing the information.

Signature of new principal member

Signature of broker

Signed at

Date D D M M Y Y Y Y

8. APPLICATION AND DECLARATION

I herewith apply for:
1. Change in membership profile due to change in employment status.
2. Change in membership profile due to principal member deceased.
3. Change due to dependant transfer to main member (main member swap).
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 registration 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