NEDBANK APPLICATION FORM (SHORTENED VERSION)

1. APPLICANT (PRINCIPAL MEMBER)

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

First name

Middle name | Initials

Surname

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

Home language

Passport number | Gender M F

Country of issue (passport)

SARS tax number (SARS legislative requirement)

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	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

3. HEALTHCARE ADVISOR DECLARATION

1. I declare that I am an accredited Bestmed healthcare advisor, I am a registered advisor in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 to sell Health Service Benefits, and an accredited broker in terms of Section 65 of the Medical Schemes Act.
2. I accept that the applicant has appointed me as his/her healthcare advisor and that he/she is entitled to terminate my services at his/her will.
3. I confirm that the applicant was given my personal details, including my physical and postal address, and contact number.
4. I acknowledge that in terms of Act 131 of 1998 in the Medical Schemes Act (or as amended), a monthly statutory commission will be paid out to me up to a maximum amount as set by the Medical Schemes Act.
5. I declare that there has been no misrepresentation of any fact by me and that, in the event of material or unlawful conduct, I will be responsible for refunding all monies paid in effect of such misrepresentation or conduct.
6. I declare that the applicant is familiar with the information required in the application form and he/she has provided all the correct information.
7. I declare that the advice and support given to the applicant was unbiased and in his/her best interest.
8. I declare that the applicant has personally signed this application form.
9. I am aware of the submission cut-off date for new registrations.

4. SUMMARY OF MONTHLY COST

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

TOTAL MONTHLY PREMIUM R .

Healthcare advisor name

Healthcare advisor code

Healthcare advisor signature

Date D D M M Y Y Y Y

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Telephone number (w)

Fax number

Telephone number (h)

Cellphone number

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

Physical address details

Address

Street

Suburb

Town/city

Postal code

Postal address details (Domicilium citandi et executandi)

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's ID number

Signature of applicant

Signature of account holder (if different from applicant)

7. PARTNERSHIP DECLARATION

Only to be completed if you are registering a partner/fiancé/common-law spouse with a surname that is different to that of the main member.

I,

(principal member name and surname) declare that I have established a partnership with

(your partner/fiancé/common-law spouse name and surname) and that we have been living together since D D M M Y Y Y Y

I declare that we intend to continue living together indefinitely, and I undertake to inform Bestmed within 30 days in the event of termination of this partnership.

Signed by me

Signature of principal member

on this

day of month Y Y Y Y

8. CHILD DECLARATION

Only to be completed if you are registering a child where the surname differs to the principal member

I,

(principal member name and surname) declare that (all children where surname's differs to principal member) is my/my spouse/my partner(s) biological child.

1.
2.
3.
4.
5.

Signed by me

Signature of principal member

on this

day of month Y Y Y Y

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

9. DEPENDANTS TO BE ADDED

1. Dependant details

First name

Surname

ID number (passport number for non-SA citizens)

Gender M F

Country of issue (passport)

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Relationship to principal member:

Email address

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

2. Dependant details

First name

Surname

ID number (passport number for non-SA citizens)

Gender M F

Country of issue (passport)

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Relationship to principal member:

Email address

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

3. Dependant details

First name

Surname

ID number (passport number for non-SA citizens)

Gender M F

Country of issue (passport)

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Relationship to principal member:

Email address

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

4. Dependant details

First name

Surname

ID number (passport number for non-SA citizens)

Gender M F

Country of issue (passport)

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Relationship to principal member:

Email address

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

10. 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

11. 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