OVERAGE DEPENDANT: CONTINUATION INDIVIDUAL APPLICATION FORM



This application form is intended for overage dependants who no longer qualify for child dependant rates.

1. APPLICANT (PRINCIPAL MEMBER)

Title				В	estmed	l join d	ate			D	D	М	М	Y	Y	Y	Y
First name																	
Middle name]	nitials				
Surname																	
ID number							Dat	e of bir	th	D	D	М	М	Y	Y	Y	Y
Home language																	
Passport number														Ge	nder	М	F
Country of issue																	
SARS tax number (mar	ndatory)																
Marital status	Unmarried Married	Date of marriage	/divorce		D	D	м	М	Y	Y	Y	Y]				
Current employer																	
Date of employment	D D M M	1 Y Y Y	Y E	mploye	ee num	ber											
2. BENEFIT OPT	ION											•		1	1		
Benefit option (indica																	
Beat1		Beat1N (Network) †			Pa	ace1						Rh	ythm1	* ‡			
Beat2		Beat2N (Network) †			Pa	ace2						Rh	ythm2	* ‡			
Beat3		Beat3N (Network) †			Pa	ace3											
Beat3 Plus					Pa	ace4											
Beat4																	
Income bracket if you	are joining on the Rhyth	nm1 Option	Inco	ome br	acket i	f you a	re join	ing on t	the Rh	ythm2	Optior	n					
R 0 - R 9 000 monthly	R 9 001 - R 14 000 monthly	R 14 001 and above monthly			R 5 50 onthly	00	R	501 - mont		0	a	R 8 50 nd abo monthl	ve				
		or bank statements - not ol highest bracket, pending p			s).												
[†] Members on any of	the BeatN options enjoy	an efficiency discount. B	selecting	one of	f the Bo	eatN o	ptions	you acl	nowle	edge ai	nd agre	e to th	e follo	wing c	onditio	ns:	

 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

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 Client Service 086 000 2378 • Fax +27 (0)12 472 6500 • E-mail membership@bestmed.co.za • www.bestmed.co.za • Reg no. 1252

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 PI	REMIU	М												R									
Healthcare advisor nar	ne																						
Healthcare advisor cod	е																						
														Dat	ρ	D	D	М	М	Y	Y	Y	Y
Healthcare advisor sign	nature													But	-								
5. ADDRESS AND		ITAC	T DE	TAILS	5 (PR	INCI	PALI	ИЕМ	BER)														
Email address																							
											1												
Telephone number (w)											J	x numt											
Telephone number (h)												llphone mber	5										
Is your physical addres	s the sa	ame as	your p	ostal a	ddress	?		Yes	ſ	No]												
Physical address							L				J												
Address																							
Street																							
Suburb																							
Town/city]	Postal	code				
Postal address details	(Domi	cilium	citandi	et exe	cutand	i)																	
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

DEBIT ORDER FOR MONTHLY CONTRIBUTIONS BANKING DETAILS

* Debit order de	ductior	date		:	20 th		25 th		1 st															
Bank																								
Branch																								
Branch code]	Туре с	f accou	nt	C	heque/	'curren	t		Savir	ngs						
Account number																								
Select account he	older		Men	nber			Compa	any*			Othe	r¥-												
*If you have select COMPANY	ted "CO	mpan	Y" or "C	DTHER"	please	comple	te the s	ections	below,	includi	ng the a	ddress	section	. This is	in acco	rdance	with SA	ARS legi	slative	require	ments.			
Registered name	e of com	pany																						
Type of company	ı (e.g. pri	ivate)																						
Entity registratio	n numb	er																						
OTHER																								
Title																								
First name																								
Middle name																								
Surname																								
Account holder l	D numb	er																						
Passport numbe	er (for no	on-SA c	itizens)																				
Country of issue	[
SARS tax numbe	er (manda	atory)											Da	te of bi	rth		D	D	М	М	Y	Y	Y	Y
Physical address (mandatory field for bot																								
"COMPANY" and "OTHE	ER")																							
																			Postal	code				
Is your physical a	Iddress	the sar	me as y	our po	stal add	ress?		Ye	S	No														
Postal address (Domicilium citandi et																								
executandi)																								
																			Postal	code				
CLAIMS REFUN Is your claims ref If you selected "I	und bar	nking d	etails t	he sam							etails?											Yes	Ν	No
Bank																								
Branch	[-													-		
Branch code	[Туре о	faccou	nt		Che	eque/ci	urrent				Sa	/ings				
Account number	[
Name of the acco	ount hol	der																						
If account holder	differs f	rom pr	incipal	membe	er, pleas	e confi	rm acco	ount ho	lder ID	number	/passp	ort num	ber for	non-S/	A citizer	าร								
Account holder I	D numb	er																						

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 piror 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

7. DEPENDANTS TO BE ADDED

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1. Dependan	t deta	ils																						
First name																								
Surname																								
ID number (passport numl	ber for i	non-SA	citizer	ıs)																	Ge	nder	М	F
Country of issu	е													Date	of birth	I	D	D	М	М	Y	Y	Y	Y
SARS tax numb	ber]											
Dependant con	tact nu	mber]											
Email address																								
dependant/s Relationship Spous If other, please (affidavit/legal	to prin e/comm e speci f	ncipal non-lav fy relat	meml w spou	ber (I n se		e with	an 'X') ^P artner	/fiancé		in sectio	on 8)						fference declarat			9)			()ther
2. Dependan	t deta	ils	~	~																				
First name																								
Surname																								
ID number (passport numl	ber for i	non-SA	citizer	ıs)																	Ge	nder	М	F
Country of issu	e]	Date	of birth	l	D	D	Μ	М	Y	Y	Y	Y
SARS tax numb	ber]											
Dependant con	tact nu	mber]											
Email address																								
	directi to prin e/comn	ly to th ncipal non-lav	mem, in meml w spou	ber (In	vith th	e POP with	I Act. an 'X') Partner	/fiancé	<u>.</u>	and old		ll allou	v Besti	med to] Chi	ld <i>(if di</i>	fference declarat	e in suri	name,		related	d to th	_	icable)ther
If other, please (affidavit/legal			ionshi	p: 																				

8. PARTNERSHIP DECLARATION

d if you	are re	gister	ing a p	artne	er/fia	ncé/c	ommo	on-lav	v spou	se wit	h a su	ırnam	e that	is diff	erent	to tha	t of th	e maiı	n mem	ber.		
mber nar	me and	l surna	me) deo	lare th	nat I h	iave es	tablish	ned														
(your pai and that	rtner/fi : we ha	iancé/o ve bee	commo n living	n-law s togeth	spous her sii	se nam nce	e and	surnam	ne)						D	D	М	М	Y	Y	Y	Y
d to cont	tinue li	ving to	gether	indefin	nitely,	and I u	Inderta	ake to i	nform	Bestme	ed with	in 30 c	lays in	the eve	ent of t	ermina	tion of	this pa	rtnersh	nip.		
								on th	nis			day	of			mont	h		Y	Y	Y	Y
ure of pri	ncipal	memb	er																			
ATIO	N																					
d if you	are re	egiste	ering a	child	whe	re the	surn	ame d	iffers	to the	princ	ipal n	nembo	er								
	wher nar (your pa and that d to com	mber name and (your partner/f and that we ha d to continue li	wher name and surna (your partner/fiancé/ and that we have been d to continue living to ure of principal memb	wher name and surname) dec (your partner/fiancé/commoi and that we have been living d to continue living together ure of principal member	where name and surname) declare the second surname) declare the second surname) declare the second surname) declare the second surname and surname and surname) declare the second surname and that we have been living together indefined and that we have be	Index name and surname) declare that I P (your partner/fiancé/common-law spous and that we have been living together sind d to continue living together indefinitely, ure of principal member CATION	Index name and surname) declare that I have est in the set is the	In the second se	mber name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surnam and that we have been living together since d to continue living together indefinitely, and I undertake to i ure of principal member CATION	In this	In the second seco	In the second secon	In the second secon	In the second secon	Image: Construction of the second	Image: constraint of the second s	Imper name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surname) and that we have been living together since Imper name and surname) Imper name and surname) (your partner/fiancé/common-law spouse name and surname) Imper name and surname) Imp	Imper name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surname) and that we have been living together since Imper name and surname) Imper name and surname) (your partner/fiancé/common-law spouse name and surname) Imper name and surname) Imp	Imper name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surname) and that we have been living together since Imper name and surname) Imper name and surname) (your partner/fiancé/common-law spouse name and surname) Imper name and surname) Imp	Imper name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surname) and that we have been living together since Imper name and surname) Imper name and surname) <	(your partner/fiancé/common-law spouse name and surname) and that we have been living together since D D M M Y Y d to continue living together indefinitely, and I undertake to inform Bestmed within 30 days in the event of termination of this partnership. on this day of month Y Y ure of principal member ATION	Imper name and surname) declare that I have established (your partner/fiancé/common-law spouse name and surname) and that we have been living together since Imper name and surname) I

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2.																										
З.																										
4.																										
5.																										
Signe	d by m	e										on thi	s			day o	f			month	I		Y	Y	Y	Y

Signature of principal member

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

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.
- $2.10 \quad \text{To provide me with health and wellness information throughout the subsistence of my membership.}$
- 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.

Ye	s	No

Signature of applicant

11. STATEMENT OF APPLICANT

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

To be completed by Member

Signature of app	licant									
Signed at				on this	day of	month	Y	Y	Y	Y