

CORPORATE APPLICATION FORM FOR REGISTRATION OF DEPENDANTS



1. APPLICANT (PRINCIPAL MEMBER)

Membership number	<input type="text"/>	Bestmed join date	<input type="text"/>
Title	<input type="text"/>	First name	<input type="text"/>
Initials	<input type="text"/>	Middle name	<input type="text"/>
Surname	<input type="text"/>		
ID number	<input type="text"/>	Date of birth	<input type="text"/>
Home language	<input type="text"/>		
Passport number	<input type="text"/>	Gender	<input type="text"/>
Country of issue	<input type="text"/>		
SARS tax number (SARS legislative requirement)	<input type="text"/>		
Marital status	<input type="text"/>	Date of marriage/divorce	<input type="text"/>
Current employer	<input type="text"/>		
Date of employment	<input type="text"/>	Employee number	<input type="text"/>

2. DEPENDANTS TO BE ADDED

1. Dependant details

First name	<input type="text"/>														
Surname	<input type="text"/>														
ID number (passport number for non-SA citizens)	<input type="text"/>										Gender	<input type="text"/>			
Country of issue	<input type="text"/>										Date of birth	<input type="text"/>			
SARS tax number	<input type="text"/>														
Dependant contact number	<input type="text"/>														
Email address	<input type="text"/>														

Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.

Relationship to principal member (Indicate with an 'X')

<input type="checkbox"/> Spouse/common law spouse	<input type="checkbox"/> Partner/fiancé (complete declaration in section 3)	<input type="checkbox"/> Child (if difference in surname, complete declaration in section 4)	<input type="checkbox"/> Other
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If other, please specify relationship:

(affidavit/legal documents and proof of income required)

2. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

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If other, please specify relationship:

(affidavit/legal documents and proof of income required) _____

3. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

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If other, please specify relationship:

(affidavit/legal documents and proof of income required) _____

4. Dependant details

First name	<input type="text"/>																							
Surname	<input type="text"/>																							
ID number (passport number for non-SA citizens)	<input type="text"/>												Gender											
	<input type="text"/>												<input type="text"/>											
Country of issue	<input type="text"/>												Date of birth											
	<input type="text"/>												<input type="text"/>											
SARS tax number	<input type="text"/>																							
Dependant contact number	<input type="text"/>																							
Email address	<input type="text"/>																							

Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.

Relationship to principal member (Indicate with an 'X')

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If other, please specify relationship:

(affidavit/legal documents and proof of income required) _____

5. Dependant details

First name																												
Surname																												
ID number (passport number for non-SA citizens)											Gender		<input type="checkbox"/> M <input type="checkbox"/> F															
Country of issue											Date of birth		<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>								D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y																					
SARS tax number																												
Dependant contact number																												
Email address																												

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<input type="checkbox"/> Spouse/common law spouse	<input type="checkbox"/> Partner/fiancé (complete declaration in section 3)	<input type="checkbox"/> Child (if difference in surname, complete declaration in section 4)	<input type="checkbox"/> Other
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If other, please specify relationship:

(affidavit/legal documents and proof of income required)

6. Dependant details

First name																												
Surname																												
ID number (passport number for non-SA citizens)											Gender		<input type="checkbox"/> M <input type="checkbox"/> F															
Country of issue											Date of birth		<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>								D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y																					
SARS tax number																												
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Provision of contact information for your dependant older than 18 years will allow Bestmed to communicate chronic information directly to the applicable dependant/s.

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If other, please specify relationship:

(affidavit/legal documents and proof of income required)

3. 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																												
<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>																					D	D	M	M	Y	Y	Y	Y
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											on this			day of			month	<table><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		Y	Y	Y	Y
Y	Y	Y	Y																				
Signature of principal member																							

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

4. CHILD DECLARATION

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

[illegible]

(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.

[illegible]

Signed by me

Signature of principal member

on this		
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day of

month

Y

Y

Y

Y

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

5. THE FOLLOWING DOCUMENTS ARE COMPULSORY

- | |
|--|
| 1. If a child is older than 24, proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant. If a child is older than 24 and unemployed, a declaration statement is required and adult rates will apply. |
| 2. In the case of extended family (parent, brother or sister only) - affidavit of dependant(s) with regards to dependency on principal member. |
| 3. 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. |
| 4. In the case of a handicapped child dependant, a report from a medical practitioner. |
| 5. If you are registering a new born baby, a birth certificate/ full ID number/ passport number will be required. It is compulsory that you register your new born baby within 30 days, from date of birth. |
| 6. Ensure that dependant(s) full names and identity numbers are completed and passport numbers required for non-SA citizen. |
| 7. Medical questionnaire: <ul style="list-style-type: none"> ▪ Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation). ▪ Signed and dated. |

6. PREVIOUS MEMBERSHIP STATUS

Please supply previous membership certificates, from a South African registered medical scheme, as relevant proof of previous medical aid cover. This submission of previous medical aid certificates will ensure correct and relevant underwriting is applied on your new profile.

Have your spouse/ partner and/ or dependant(s) been a member(s) or dependant(s) of a medical scheme(s)?

Yes

No

If "yes", attach the membership certificate(s) of the previous scheme(s), confirming the start and end date of membership

Name of scheme	Member number	Principal member	Dependant	Date from	Date to

7. MEDICAL QUESTIONNAIRE

12.1 Please note: Where the answer is YES, please give full details of the person concerned in the space provided. If 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. The examples listed under each condition below is not intended as a full list of conditions, disorders or symptoms, but only serve as examples. **The examples listed with each section is only a limited list and does not include all possible conditions.**

Have any of your proposed beneficiary-(ies) received any medical advice, diagnosis, care or was recommended for treatment for the following, within the 12- month period ending on the date on which you are applying for membership. Please clearly specify/underline the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Date diagnosed	Last treatment date	Please state diagnosis, medicine and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms in the last 12 months
1. Congenital physical deviations: e.g. bat ears, valvular heart disease	Yes	No				
2. Skin conditions/abnormalities (including allergies): e.g. eczema, psoriasis, acne	Yes	No				
3. Skeletal, joint and muscle deviations/problems: e.g. arthritis, back/knee problems, jaw surgery/problems	Yes	No				
4. Sensory organ problems: hearing, speech, vision (including spectacles and/or contact lenses)	Yes	No				
5. Lung/respiratory problems: e.g. asthma, COPD, bronchitis, bronchiolitis, pulmonary embolism	Yes	No				
6. Heart/Cardio-vascular problems: e.g. hypertension, high cholesterol, heart failure, thrombosis, bypass surgery	Yes	No				
7. Digestive problems: e.g. hiatus hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, liver or pancreas problems	Yes	No				
8. Urinary system problems: e.g. kidney infections/failure/dialysis/stones, bladder problems/infection, incontinence	Yes	No				
9. Metabolic diseases: e.g. obesity, diabetes type 1 or 2, porphyria, thyroid problems	Yes	No				
10. Mental/psychiatric problems: e.g. depression, anxiety, bipolar mood disorder, sleeping disorders, counselling	Yes	No				
11. Muscular/nervous system: e.g. paralysis, epilepsy, Parkinson's disease, headaches, Stroke, cerebral palsy, paraplegia, hemiplegia, amputations	Yes	No				
12. Substance abuse/dependence: e.g. alcohol, drugs, recent rehabilitation	Yes	No				
13. Cancer diagnosis/treatment, a growth or tumour of any kind? Please state type.	Yes	No				
14. Dental treatment: e.g. fillings, braces, crowns, dentures	Yes	No				
15. Ear, nose and throat problems: e.g. grommets, tonsillitis, sinus/nasal surgery, sinusitis	Yes	No				
16. Any previous operations undergone?	Yes	No				

8. UNDERWRITING POLICY

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.

Bestmed will implement waiting periods and evaluate and/or investigate information and membership in all cases where adverse selection is exercised to obtain specific benefits.

Monitor for possible non-disclosure

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

- Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
- When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application.

In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation.

In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

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

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

Number of years since age 35 where applicant was not a member of a medical scheme	Penalty
1 - 4 years	0.05 x risk contribution
5 - 14 years	0.25 x risk contribution
15 - 24 years	0.50 x risk contribution
25+ years	0.75 x risk contribution

9. APPLICATION AND DECLARATION

I herewith apply for:

Recognition of my abovementioned dependants as beneficiary(ies) of the Scheme on the grounds that, to the best of my knowledge:

- The details in respect of your dependant(s) set out above are true and correct and that they qualify for enrolment as dependant(s) in terms of the Scheme Rules;
- My aforementioned children are fully dependant on me;
- My aforementioned dependants are in good health, both mentally and physically. Should an applicant be unable to sign the declaration as required in (1) and (2) on account of temporary absence of a dependant or on account of ill health or of a mental or physical disability of such a dependant, full details should be submitted to the Scheme for consideration.

I undertake on behalf of the above mentioned dependant(s) to abide by 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

on this

day of

month

Y

Y

Y

Y

* The rules of the Scheme 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 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
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Signature

11. STATEMENT BY EMPLOYER

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

We (employer name)

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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.

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Signature of employer

HR practitioner details

Surname

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Full names

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E-mail

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Telephone number

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Remarks

Signature of HR practitioner

Date

D	D	M	M	Y	Y	Y	Y
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Name stamp of employer