This check list is for HR practitioners to check and ensure all the information is on the application form and all the documents that are required have been attached. It will further assist in the processing of applications and minimise delays in activation of the employees new medical scheme.

The Employee Must Sign Off On The Check List.

AON

## CHECKLIST FOR APPLICATIONS

**Please provide the following documentation with the application**

**Please read and answer all the questions**

**Are the relevant documents attached?**

| | | | | |
|---|---|---|---|---|
| Is an affidavit attached if registering a common law spouse or partner? | Yes | | No | |
| Is the application signed and stamped by Transnet HR practitioner(this is to confirm that you are an employee of Transnet).? | Yes | | No | |
| You understand that the completed applications must be scanned to transnetapps@aon.co.za or faxed to 086 726 7146? | Yes | | No | |
| Have you answered all the questions? | Yes | | No | |
| Are all the Birth Certificates of Children where ID is not yet available attached? | Yes | | No | |
| Do you understand that you should not resign until you accepted at the new medical scheme? | Yes | | No | |
| Do you understand that you have to give your existing medical scheme there notice period? | Yes | | No | |
| Have you attached the Documentary proof in case of adopted/foster child? | Yes | | No | |
| Have you allocated your commencement date? | Yes | | No | |
| Have you allocated your date of employment? | Yes | | No | |
| Have you completed the section for your banking details for the medical scheme to refund you for claims? | Yes | | No | |
| Have you selected your option? | Yes | | No | |
| Have you signed and dated the declaration? | Yes | | No | |
| Have you signed on all the applicable sections? | Yes | | No | |
| Are all the ID Documents for yourself and all your dependants attached? | Yes | | No | |
| Have you allocated your ID number and SAP number on the application? | Yes | | No | |
| If you altered your application, did you sign next to the alteration? | Yes | | No | |
| If you answered yes to any questions - have you given an explanation to the questions? | Yes | | No | |
| Is your Marriage certificate attached if you regisstering a spouse? | Yes | | No | |
| Have you attached the Membership certificates with termination dates from your previous medical schemes? | Yes | | No | |
| Have you allocated contact details in order to be contacted? | Yes | | No | |
| Have you given your full Postal address with postal codes? | Yes | | No | |
| Have you attached Proof(payslip) of your taxable income, (Income Band Options only)? | Yes | | No | |
| Have you specified your Business Unit clearly on the application? | Yes | | No | |
| Do you fully understand that your application will not be processed until a fully completed application is received by the medical scheme with all the supporting documents? | Yes | | No | |

**Employee Full Name & Surname:**

**Date:**

**Employee Signature:**

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

# INDIVIDUAL APPLICATION FORM

Transnet Pensioner

bestMed

## 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

SARS tax number (mandatory)

Marital status Unmarried Married | Date of marriage/divorce D D M M Y Y Y Y

Current employer

Date of employment D D M M Y Y Y Y | Employee 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

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

## 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: Deidre Marx

Healthcare advisor code: 4554

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

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 physical address the same as your postal address? Yes / No

**Physical address**

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

**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

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

## 7. DEPENDANTS TO BE ADDED

### 1. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

### 2. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

### 3. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

### 4. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

### 5. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

### 6. Dependant details

First name

Surname

ID number
(passport number for non-SA citizens)

Gender M F

Country of issue

Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

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.***

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

☐ Spouse/common-law spouse ☐ Partner/fiancé *(complete declaration in section 8)* ☐ Child *(if difference in surname, complete declaration in section 9)* ☐ Other

**If other, please specify relationship:**
*(affidavit/legal documents)*

## 8. 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

## 9. 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.

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

## 10. 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:

a) 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.
b) 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 |

## 11. PREVIOUS MEMBERSHIP STATUS

**Please supply ALL previous membership certificates, from a South African registered medical scheme for you and your dependants, as relevant proof of previous medical aid cover. The submission of previous medical aid certificates will ensure correct and relevant underwriting is applied on your new profile. In the event that you are unable to obtain previous membership certificate(s), Bestmed will accept an affidavit if previous cover exceeds 5 years. Visit www.bestmed.co.za to complete affidavit in the relevant blocks. Please refer to applicant checklist (section14) of this form for more details.**

| | | |
|---|---|---|
| Have you and/or your spouse/partner and/or dependant(s) been a member or dependant of a medical scheme? | Yes | No |
| I was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months with no break in membership between previous medical scheme and Bestmed, contributions at my previous scheme were paid in arrears therefore I would like to continue to pay Bestmed in arrears. | Yes | No |

**According to the Medical Scheme's Act a member/dependant may not belong to 2 medical schemes at the same time therefore it is imperative that we receive a certificate with a resign date to continue with the registration process.**

**If "yes" please attach all previous membership certificates**

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

## 12. MEDICAL QUESTIONNAIRE

**12.1 This section is extremely important:**
**Please complete the following questionnaire** to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders, irrespective of it being chronic or acute and no matter how insignificant it may seem. **If the answer is YES, please give full details of the person and condition concerned in the space provided**. If the space provided is insufficient, provide the details on a separate page and attach it to this questionnaire, medical reports may be included. **The examples listed under each condition below are not intended as a full list of conditions, disorders or symptoms, but only serve as examples. In other words, the examples below are only a limited list and do not include all possible conditions.** **Please note that all fields are compulsory.**

| Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? **Please clearly specify the diagnosed conditions in relevant tables.** | Indicate with an "X" (compulsory) | | Name of patient | Specify illness/condition/ disorder in full | Date of first diagnosis or problem | Latest consultation/ test/treatments with dates | Please state ALL medicines: name and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms, dates of last symptoms experienced |
|---|---|---|---|---|---|---|---|
| 1. Infectious diseases e.g. hepatitis B, tuberculosis, tetanus, bilharzia, etc. | Yes | No | | | | | |
| 2. Positive for HIV/AIDS* | Yes | No | | | | | |
| * If you and/or any of your dependants are HIV positive or have AIDS and would prefer not to disclose your and/or their HIV status on this form due to confidentiality, then you must call 012 472 6249 or send an e-mail to mhc@bestmed.co.za in order to notify Bestmed of your and/or your dependant(s) that you and/or your dependants are living with HIV/AIDS. This information must be disclosed to Bestmed within seven (7) working days from the application date of your and/or your dependant(s) membership. On receipt of this request Bestmed will determine whether underwriting conditions will be applied, and if this is the case, you will receive an amended proof of membership document. | | | | | | | |
| 3. Cancer diagnosis/treatment, or a growth or tumour of any kind? Please state type - benign or malignant. | Yes | No | | | | | |
| 4. Blood conditions: e.g. anaemia, blood clotting problems, deep vein thrombosis, pulmonary embolism, platelet deficiencies, haemophilia, leukaemia, lymphoma, bleeding disorders. | Yes | No | | | | | |
| 5. Endocrine and metabolic conditions : e.g. obesity, diabetes mellitus, porphyria, thyroid problems, Cushing syndrome, metabolic syndrome, Addison disease, any other endocrine or metabolic conditions | Yes | No | | | | | |
| 6. Psychiatric conditions: e.g. depression, anxiety, bipolar disorder, autism, Asperger syndrome, sleeping disorders (e.g. narcolepsy), insomnia, eating disorders, drug or alcohol use disorder or rehabilitation, suicide attempt, post-traumatic stress disorder, counselling, recent psychological trauma. | Yes | No | | | | | |
| 7. Brain and nervous system or neuromuscular conditions: e.g. paralysis, epilepsy, Parkinson disease, headaches, stroke, cerebral palsy, paraplegia, hemiplegia, carpal tunnel syndrome, chronic headache, migraine, multiple sclerosis, motor neuron disease, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability. | Yes | No | | | | | |
| 8. Eye and eyelid conditions: e.g. vision problems, blurry vision, glasses, cataracts, keratoconus, corneal ulcers, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, corneal transplant, eye surgery, partial or full blindness, astigmatism, any other eye or eyelid condition. | Yes | No | | | | | |
| 9. Ear, nose and throat problems: e.g. grommets, otitis media, tinnitus, ear infections, deafness, hearing problems, use of hearing aids, cochlear implant, tonsillitis or adenoiditis, dizziness, vertigo, previous sinus or nasal surgery, sinusitis, deviated nasal septum, allergic rhinitis, chronic blocked nose or sinuses. | Yes | No | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10. Heart and circulation problems: e.g. high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins. | Yes | No | | | | | |
| 11. Lung and breathing problems: e.g. asthma, COPD/emphysema, bronchitis, bronchiolitis, pulmonary embolism, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia. | Yes | No | | | | | |
| 12. Digestive and gastrointestinal problems: e.g. hiatus/abdominal/inguinal hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, hepatitis, cirrhosis, portal hypertension, alcohol or fatty liver disease, liver failure, pancreatitis, cystic fibrosis, Crohn disease, ulcerative colitis, diverticulitis, jaundice. | Yes | No | | | | | |
| 13. Skin condition (including allergies): e.g. eczema, psoriasis, acne, chronic wounds, melanoma, skin cancer, sunspots, warts, skin tags, mole irritation or shape and colour change. | Yes | No | | | | | |
| 14. Dental, oral, and maxillofacial consultation and/or treatment: e.g. dental fillings, orthodontics, crowns, dentures, implants, temporomandibular joint disorders, jaw surgery, cleft lip or palate, etc. | Yes | No | | | | | |
| 15. Skeletal, joint and muscle deviations/problems: e.g. neck/back/knee/hip problems/pain, arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus (SLE), gout, clubfoot, bunions, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, etc | Yes | No | | | | | |
| 16. Kidney and urinary conditions: e.g. kidney failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, etc. | Yes | No | | | | | |
| 17. Male reproductive system: e.g. prostate cancer, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, vasectomy, circumcision, erectile dysfunction, etc. | Yes | No | | | | | |
| 18. Pregnancy or suspected pregnancy? If yes, please confirm gestation/duration of pregnancy. Are you currently undergoing treatment towards getting pregnant? Provide date of Last Normal Menstruation (LNM). | Yes | No | | | | | |
| 19. Female reproductive system: e.g. endometriosis, menstrual problems or irregularities, infertility, hormone replacement therapy, sterilisation/ hysterectomy, abnormal Pap smear result, polycystic ovarian syndrome, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, etc. | Yes | No | | | | | |
| 20. Congenital deviations: e.g. bat ears, cleft palate, patent ductus arteriosus (PDA), heart defects, Down Syndrome, neural tube defects, spina bifida, brain defects, ventricular septum defect (VSD), etc. | Yes | No | | | | | |
| 21. Rare disorders/conditions: e.g. congenital disorders of glycosylation, Hunter syndrome, lysosomal storage diseases, Klinefelter syndrome, etc. | Yes | No | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 22. Any symptoms experienced, or other illness/medical condition that you are aware of not mentioned above, even if no doctor was consulted and irrespective of treated with lifestyle changes or self-medication? | Yes | No | | | | | |
| 23. Current medication used, not yet stated above, even if not on a chronic basis. If yes, please attach a list if this space is not sufficient. | Yes | No | | | | | |
| 24. Any previous operations undergone? | Yes | No | | | | | |
| 25. A condition for which you and/or your dependant(s) received a payment and/or medical treatment of whatever nature: e.g. third party claim. | Yes | No | | | | | |
| 26. Any other medical condition or ongoing treatment/monitoring that is not mentioned on the application form that may result in a claim within the next 12 months? | Yes | No | | | | | |

**Please note that the complete medical questionnaire does not serve as an application for chronic benefits, kindly download and complete separate chronic application form from our website; if registered for chronic medication at the previous medical scheme, submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription, approval is subject to protocols.**

**Important:** It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all the dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. Any misstatement in, or omission from this form whether wilful or in ignorance may lead to refusal to admit any claims, suspension or termination of membership. Should a new medical condition arise between the time of completing this application form and the commencement date of membership, the Scheme must be informed immediately. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact **Bestmed's Contact Centre on 086 000 2378**

I

(principal member name and surname) acknowledge that all information declared above is true and correct.

Signed by me

Signature of principal member

on this

day of

month Y Y Y Y

## 13. 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

## 14. APPLICANT CHECKLIST

**Please ensure the following compulsory documents/information are completed and attached.**

| |
|---|
| 1. If the child is older than 24 years, a declaration statement is required. Adult rates will be applicable. |
| 2. In the case of extended family (parent, brother or sister, grandchild) - 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: Previous membership card/s not accepted). The aforesaid proof must contain the period of cover. |
| 4. Upon completing an affidavit, ensure full details are disclosed e.g. applicable dependants, day, month, year, names of previous schemes. |
| 5. If disabled, please complete a report by your medical practitioner or ITRDD SARS form. |
| 6. If you selected a Bestmed Rhythm option, provide proof of income for both the main member and spouse (3 months' payslips or bank statements - not older than 3 months). |
| 7. Ensure that dependant(s) full names and identity numbers are completed. Passport numbers and Country of Issue required for non-SA citizen. |
| 8. Medical questionnaire:<br>▪ Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, dates of last symptoms experienced, diagnosed condition, medicine and dosage, nature of treatment, level/stages of illness and hospitalisation). |
| 9. Chronic application:<br>▪ If registered for chronic medication at the previous medical scheme, submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription, approval is subject to protocols. |

## 15. STATEMENT OF APPLICANT

I

(principal member name and surname) hereby declare that:

a. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;

b. By signing this form, I agree to the terms and conditions of Bestmed's Beat network options and Rhythm options where applicable.

c. The information furnished herein is completely true and correct to the best of my knowledge and conviction and that I have not omitted or concealed any information; I accept that a savings account will be allocated pro rata (if applicable);

d. I understand that if my application for membership is approved and accepted, the information furnished on my application form will be used as the basis of my application and the payment of benefits in the future;

e. I irrevocably hereby grant permission on behalf of myself as well as on behalf of my dependant(s) (if applicable) to any physician, person or party who may be in possession of or obtain information concerning my state of health or that of my dependant(s), treatment received or expected as well as any other relevant information to divulge such information to Bestmed or its proxy on demand, also after my death or that of my dependant(s); I understand that this information together with other information will be used to evaluate the payment of benefits for certain medical conditions, I warrant that I have obtained my dependant(s) consent to grant this authorisation;

f. I undertake to pay my share of accounts to Bestmed; on default, I hereby authorise my employer/business to deduct the amount due from my salary or should I resign, I hereby authorise my employer/business to deduct the amount due from my pension or any other monies due to me and pay this over to Bestmed;

g. I acknowledge that my date of application does not necessarily refer to my date of admission as a member of Bestmed. I further acknowledge that my date of admission will be communicated to me by Bestmed as soon as possible hereafter.

h. Any deterioration or change in my state of health or in that of my dependant(s) before the date or event to be set by Bestmed for commencement of membership, or the date of acceptance of this application by Bestmed, or the date of receipt of the first subscription, whichever date is the latest shall entitle Bestmed to reconsider the application and propose new terms of admission.

i. If after or during my admission as a member of Bestmed it is found that any statement or information furnished by me was knowingly and/or wilfully inadequate, incomplete or untrue, Bestmed reserves the right to cancel the membership. If such is the case, I agree to refund in full to Bestmed all payments which Bestmed may have made on my behalf and to relinquish any claim to any benefits on the part of Bestmed;

**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.**

Signature of applicant

Signed at

on this day of month Y Y Y Y

**Cut-off date for submission of new applications is the 27th of the month, this is to secure the following months start date. Incomplete applications or missing documents may impede the start date.**

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

# BROKER APPOINTMENT FORM

**This form is used for the appointment of a registered healthcare advisor and/or replacing your current healthcare advisor, as well as for you to provide consent regarding the sharing of personal and/or special personal information with your newly appointed healthcare advisor.**

## 1. MEMBER DETAILS

First name

Middle name | Initials

Surname

ID number

Membership number | Contact number

Email address

## 2. EMPLOYER DETAILS

Employer name: Transnet

Town/Area/Station

Employer number

## 3. BROKER DETAILS

Brokerage name: Aon South Africa

Brokerage code: AONN01A1ITRN

Broker name: Deidre Marx

Broker code: 4554

## 4. DECLARATION AND CONFIRMATION OF APPOINTMENT

I,

hereby confirm that I am duly authorised to appoint the Broker mentioned above ("the Broker"), to act as my agent for purposes of all my dealings with Bestmed Medical Scheme ("Bestmed").

## 5. CONSENT

- I hereby give specific and informed consent for Bestmed to share my Personal and/or Special Personal Information, as well as the Personal and/or Special Personal information of my dependants, as defined in the Protection of Personal Information Act, 4 of 2013 ("POPIA") with the Broker.
- In as far as I provide Bestmed with the Personal and/or Special Personal Information of any third party, including my spouse(s), children or other dependants – to be shared with the Broker that I hereby appoint – I hereby warrant that I have acquired the consent of such third party to do so. 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 POPIA.

- I acknowledge that the Personal and/or Special Personal Information includes but is not limited to my/my dependants' health, medical and treatment records, which may include:

| Biographical information | Benefit information | Financial information | Medical information |
|---|---|---|---|
| ▪ Membership number<br>▪ Date of birth<br>▪ ID number<br>▪ Postal address<br>▪ Residential address<br>▪ Email address<br>▪ Contact numbers | ▪ Benefit option<br>▪ Available medical savings account balance<br>▪ Available benefits<br>▪ Limits on benefit option<br>▪ Waiting period information | ▪ Monthly subscription<br>▪ Tax certificate<br>▪ Membership certificate<br>▪ Balance due or outstanding | ▪ Chronic or prescribed minimum benefit conditions details<br>▪ Status of authorisations<br>▪ Claim transaction history<br>▪ Medication used<br>▪ Medical procedures performed as well as procedure codes |

- I, therefore, indemnify and hold Bestmed harmless against any claims of whatever nature, including direct, indirect, and consequential loss, resulting from the wrongful or unauthorised use of shared Personal and/or Special Personal Information, that may arise from any disclosure contemplated herein.
- I confirm that this consent will remain in effect until I expressly withdraw it in writing.

## 6. IMPORTANT TO NOTE

- This appointment shall become effective on the 1st day of the month following receipt of this Broker Appointment Form ("the Form") by Bestmed, provided that the Form is received before the last day of the month.
- The effective date cannot be backdated.
- For employer groups, please attach an original letter on the employer's letterhead, duly signed by the employer's authorised person, authorising the appointment of the Broker.
- Please send the duly completed Form by email to **commissions@bestmed.co.za**

## 7. MEMBER SIGNATURE

Name

Membership number

Signature of member

Date D D M M Y Y Y Y

## 8. BROKER SIGNATURE

Name D e i d r e M a r x

Broker code 4 5 5 4

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

Signature of broker

Date D D M M Y Y Y Y

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

## ATTENTION:

## TO WHOM IT MAY CONCERN

## TENDERING OF RESIGNATION OF TRANSMED MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the **TRANSMED Medical Scheme** effective immediately.

Since the rules of the scheme state I have to give **A ONE MONTH CALANDER NOTICE**, my last day on **TRANSMED Medical Scheme** will be: ____/____/_____

Kind regards

_____

Signature

**PLEASE EMAIL THIS RESIGNATION TO ENQUIRIES@TRANSMED.CO.ZA BUT ATTACH THE COPY TO YOUR NEW APPLICATION.**

## ATTENTION:

## TO WHOM IT MAY CONCERN

## TENDERING OF RESIGNATION OF MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the _____

Medical Scheme effective immediately.

Since the rules of the scheme state I have to give _____ days' notice, my last day on

_____ Medical

Scheme will be: ____/____/_____

Kind regards

_____

Signature

**PLEASE SEND TO YOUR MEDICAL SCHEME BUT ATTACH A COPY TO YOUR APPLICATION FORM.**

# Benefits of appointing

## Aon South Africa Healthcare as your intermediary

**Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.**

### Our philosophy is to:

**Guide:**
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

**Educate:**
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

**Protect:**
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

### Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
  - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

### Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

### Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

### Aon Employee Benefits – Healthcare



### Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

### POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.

14 December 2022 | V2 | DD

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

## Acknowledgement of appointment

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: _____ and membership number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax (VAT).

**Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.**

I give consent for the disclosure of information about me.

Membership number: _____ ID or passport number: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed financial advisor as is necessary:

| Personal examples | Benefit examples | Financial examples | Medical examples |
|---|---|---|---|
| * Name and Surname<br>* Membership number<br>* Date of birth<br>* ID number<br>* Postal Address<br>* Physical address<br>* E-mail Address<br>* Telephone numbers<br>* Cellular Number<br>* Number of dependents | * Plan type<br>* Medical Savings Account (MSA)<br>* Balance Medical Scheme benefits<br>* Spent for the year Accumulated<br>* Medical scheme Savings Account<br>* Medical Savings Carry over from previous year<br>* MSA reimbursement, Scheme Rate or cost<br>* Self-payment Gap<br>* Above Threshold Benefit<br>* Waiting period details<br>* Late joiner penalty indicator<br>* Wellness benefits | * Total Contribution<br>* Contribution breakdown | * Chronic Indicator/ confirmation (Yes/No)<br>* In Hospital Indicator/ confirmation (Yes/No)<br>* Confirmation of claims paid and from what benefit<br>* Claims transaction history<br>* Procedures done in doctor's rooms paid from Hospital Benefit |

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AONN01A1ITRN