PERMISSION TO CHANGE BANKING DETAILS - MEMBER



FORM TO CHANGE BANKING DETAILS

What you must do

Please go through these two steps:

Step 1: Fill in the form from **step 1-5**.

Step 2: Sign the application at **step 6 and 7**.

How to complete this form

- To avoid administration delays, please make sure this form is completed in full.
- Once completed, please e-mail your form to membership@bestmed.co.za

Your banking details will only be changed if:

- 1. The information on this form matches the information on Bestmed's records at the moment.
- 2. This form has been signed by the principal member as well as the account holder, if different.

NOTE: PLEASE ATTACH THE FOLLOWING

NOTE: PLEASE AT	ACITI	HE I	-OLL	JVVIIV	.													
NOTE: Proof of bank acc	ount not	older	than 3	months	must b	e atta	ched h	ereto f	for ver	ificatio	on pur	poses						
1. BANK DETAILS T	O BE C	HAN	IGED															
Contributions					Claim	IS						All						
2. PRINCIPAL MEM	BER'S	DET	AILS															
Membership number																		
ID number																		
Cellphone number]		Teleph numb								
E-mail																		
l,																		
(Name & surname) as pri	incipal m	ember	give B	estmed _l	permiss	ion to	change	my ba	anking	details	5.							
3. PREVIOUS ACCO	UNT D	ETAI	LS															
Account holder																		
Bank																		
Branch name													Ві	ranch	code			
Account number																		
Type of account	Ch	neque			Saving	gs												

Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, RSA PO Box 2297, Pretoria, 0001, RSA

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. NEW ACCOU	INT C	ETA	ILS																				
Effective date for ch	nange	D	D	М	M	Υ	Υ	Υ	Υ		*	Debit o	rder de	ductio	n date		2	20 th		25 th		1 st	
Account holder																							
Bank																							
Branch																							
Branch code]	Type o	f accou	nt	C	heque/	curren	t		Savin	gs			<u> </u>			
Account number																							
Select account		Men	nber			*Comp	any			*Othe	er												
holder *If you have selected COMPANY	"COMPA	NY" or	"OTHE	R" pleas	se comp	olete the	section	ns belo	w, inclu	ding the	e addre	ss section	on. This	is in ac	cordan	e with 9	SARS le	gislativ	e requi	rement	s.		
Registered name of c	ompany	/																					
Type of company (e.g	. private)																					
Entity registration nu	mber										T												T
OTHER																							
Title																							
First name																							
Middle name																							
Surname																						\top	T
Account holder ID nu	mber																						
Passport number (fo	r non-S <i>i</i>	A citizeı	ns)																				
Country of issue																							
SARS tax number (m	andatory)												Date of	birth		D	D	M	М	Υ	Υ	Υ	Υ
Physical address (mandatory field for both																							
"COMPANY" and "OTHER")																							
							_			<u> </u>								Posta	al code				
Is your physical address Postal address	ess the s	same as	s your p	ostal a	ddress	?		Yes	N	lo													
(Domicilium citandi et executandi)		_	_		_					_					_		-			_			
																		Posta	al code				+
CLAIMS REFUND BA Is your claims refun If you selected NO,	d banki	ng deta	ails the							king de	etails							1 030	ii couc		Yes		lo
Bank	picasc		lic you	Ciaiiii	reiun	la barik	ing acc	ans bei															
Branch																							
Branch code]	Type o	f accou	nt		Che	eque/c	urrent	<u>I</u>			Sa	vings	l .			
Account number																							
Name of the account	:																						
If account holder diffe	ers from	princip	al men	nber, pl	ease co	nfirm a	ccount	holder I	ID num	ber/pas	ssport n	umber	for non	-SA citi	zens				I .	<u> </u>			
Account holder ID nu	ımber																						

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 e-mail, 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.

5. RELATIONSHIP OF ACCOUNT	NT HOLDER TO MAIN MEN	MBER			
Relationship to principal member					
6. SIGNATURE					
Signed at			Date	D D M M	Y Y Y Y
Signature of principal member			ignature of account ho	older	

7. CONSENT PROVISIONS BY PRINCIPAL MEMBER

- 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.
- 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
1		

Signature of principal member