CORPORATE APPLICATION FORM



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3. Hospital network

2. Specialist network (Referral required from network GP)

Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, RSA • PO Box 2297, Pretoria, 0001, RSA • Client Service 086 000 2378 • Fax +27 (0)12 472 6500 • E-mail membership@bestmed.co.za • www.bestmed.co.za • Reg no. 1252

3. HEALTHCARE ADVISOR DECLARATION

1. I declare that I am an accredited Bestmed healthcare advisor, I am a registered advisor in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 to sell Health Service Benefits, and an accredited broker in terms of Section 65 of the Medical Schemes Act. 2. I accept that the applicant has appointed me as his/her healthcare advisor and that he/she is entitled to terminate my services at his/her will. 3. I confirm that the applicant was given my personal details, including my physical and postal address, and contact number. 4. I acknowledge that in terms of Act 131 of 1998 in the Medical Schemes Act (or as amended), a monthly statutory commission will be paid out to me up to a maximum amount as set by the Medical Schemes Act. 5. I declare that there has been no misrepresentation of any fact by me and that, in the event of material or unlawful conduct, I will be responsible for refunding all monies paid in effect of such misrepresentation or conduct. 6. I declare that the applicant is familiar with the information required in the application form and he/she has provided all the correct information. 7. I declare that the advice and support given to the applicant was unbiased and in his/her best interest. 8. I declare that the applicant has personally signed this application form. 9. I am aware of the submission cut-off date for new registrations. 4. SUMMARY OF MONTHLY COST Failure to complete the below section in full will result in unsuccessful broker commission payments **TOTAL MONTHLY PREMIUM** R Healthcare advisor name Healthcare advisor code Date M Μ Healthcare advisor signature 5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER) Email address Telephone number (w) Fax number Cellphone Telephone number (h) number No Is your home address the same as your postal address? Yes Physical address details Address Street Suburb Town/city Postal code Postal address details (Domicilium citandi et executandi) Address Street Suburb

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.

Postal code

Town/city

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

10. UNDERWRITING POLICY

It is important to note that proof of previous membership may prevent possible waiting periods being imposed:

Bestmed will do NO risk underwriting in respect of staff of participating employers who apply for registration as Principal members within 90 (ninety) days of the date of permanent appointment, marriage or divorce.

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 previous membership certificates, from a South African registered medical scheme, 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.

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

Yes	No
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According to the Medical Scheme's Act a member/dependant may not belong to 2 medical schemes at the same time.

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.		te with "X" ulsory)	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
Infectious diseases e.g. hepatitis B, tuberculosis, tetanus, bilharzia, etc.	Yes	No					
	163	140					
2. Positive for HIV/AIDS*	.,						
	Yes	No					
* If you and/or any of your dependants are HIV positive or have AIDS and would prefer Bestmed of your and/or your dependant(s) that you and/or your dependants are living receipt of this request Bestmed will determine whether underwriting conditions will be	with HIV	/AIDS. Th	is information must be disclosed to I	Bestmed within seven (7) v	working days from t		
 Cancer diagnosis/treatment, or a growth or tumour of any kind? Please state type - benign or malignant. 							
type sengeror mangrand	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					
 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					
 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 	Yes	No					
neuron disease, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability.	103	140					
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					
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,	Yes	No	
aneurysm, arterial disease, chronic venous insufficiency, varicose veins.			
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					
 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					
 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					
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					
		1					
Please note that the complete medical questionnaire does not serve as a medication at the previous medical scheme, submit a copy of the previou							
medication at the previous medical scheme, submit a copy of the previou	S CHITOH	ic autii	orisation letter together with a	copy of the most rece	int prescription,	approvai is subje	ect to protocois.
Important: It remains the responsibility of the applicant to make full disclosure of the	require	d inform	ation pertaining to the applicant and	or all the dependants. S	hould you wish to a	dd a medical repor	t from your family practitioner you are welcome to d

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																						
(prir	cipal me	mber r	iame ai	nd sur	name) a	acknow	/ledge	that all	inform	ation d	leclare	d above	is true	e and co	orrect.							
Signed by me										on th	iis			day	of		month	1	Υ	Υ	Υ	Υ
	Signat	ure of	principa	al men	nber																	

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.
- 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	1	Vo

Signature of applicant

14. APPLICANT CHECKLIST

Please ensure the following	compulsor	/ documents/	information	are comp	leted and	d attached
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- 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:
 - 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:
 - 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												 1 1	
												 1 1	

(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 app	olicant												
Signature or app	Jircuite												
Signed at						on this		day of	month	Υ	Υ	Υ	Υ

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.

16. STATEMENT BY EMPLOYER

To be completed by Employer	to be completed by Employer (ALL FIELDS COMPULSORY)																					
We (employer name)																						

- 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.	

HR practitioner details																						
Surname																						
Full names																						
E-mail																						
Telephone number																						
State that the applica	nt																					
a. Has been perma r	ently	emplo	yed by	us sinc	e										D	D	M	M	Υ	Υ	Υ	Υ
b. Bestmed membership to start															D	D	M	M	Υ	Y	Υ	Υ
c. Department																						
d. Employee number																						
e. Total monthly cor	e. Total monthly contribution to be paid to Bestmed													R								
Remarks	Nemarks																					
Signature of HR practitioner																						
													- 1									

Name stamp of employer

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Date

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