TELKOM APPLICATION FORM
TELKOM AANSOEKVORM

bestMed

1. APPLICANT (PRINCIPAL MEMBER) / AANSOEKER (HOOFLID)

Title / Titel

Bestmed Join date / Bestmed aanvangsdatum D D M M Y Y Y Y

First Name / Eerste naam

Middle Name / Middel Naam

Initials / Voorletters

Surname / Van

Gender / Geslag M F

ID number / ID-nommer

Passport Number / Paspoortnommer

Preferred language / Taalvoorkeur Eng Afr

Date of birth / Geboortedatum D D M M Y Y Y Y

Marital status / Huwelikstatus Unmarried Married

Date of marriage/divorce / Datum van huwelik/egskeuding D D M M Y Y Y Y

Date of Employment / Aanstellingsdatum D D M M Y Y Y Y

Employee Number / Werknemer

2. BENEFIT OPTION / VOORDEELOPSIE

Benefit option (indicate with 'X') / Voordeelopsie (dui aan met 'X')

Beat1	
Beat2	
Beat3	
Beat4	

Beat1N (Network) †	
Beat2N (Network) †	
Beat3N (Network) †	

Pace1	
Pace2	
Pace3	
Pace4	

Pulse1 * ‡	
Pulse2 ‡	

Basic salary per anum/ Jaarlikse basiese salaris R .

Income bracket if you are joining on the Pulse 1 Option/ Inkomste kategorie as u aansluit op die Pulse 1 opsie:

0 - R 5 500 monthly/maandeliks	R 5 501 - R 8 500 monthly/maandeliks	Above/Bo R 8 501 monthly/maandeliks

* Please note that you will be registered on the highest interval, pending confirmation from your HR.
* Let wel dat u op die hoogste interval geregistreer sal word, tot bevestiging van u Personeelkontoor ontvang word.

† Take note: If any of the BeatN options is selected, please initial next to the acknowledgements below. Due to the efficiency discount imposed on the BeatN options, I acknowledge and agree to the following:
Let wel: Indien enige van die BeatN opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die doeltreffendheidsafslag wat op die BeatN opsies van toepassing is, neem ek kennis en stem toe tot die volgende:

Initial / Parafeer

1. I am limited to a hospital network and designated service providers as determined by the Scheme.
1. Ek is beperk tot 'n hospitaalnetwerk en aangewese diens verskaffers soos deur die Skema bepaal.

2. I am aware of the location of the nearest above-mentioned network hospital providers.
2. Ek is bewus van die naaste bovermelde hospitaal netwerkverskaffers se ligging.

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.
3. As ek uit vrye keuse nie van die voormelde netwerkverskaffers gebruik maak nie, is ek bewus daarvan en stem ek toe dat ek verantwoordelik gehou sal word vir 'n bybetaling in gevolge die Skemareëls.

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.
4. Ek is bewus dat hierdie 'n unieke voordeelopsie is en dat ek nie gedurende die jaar van 'n BeatN-opsie na 'n standaard Beat-opsie, in gevolge van die Skemareëls, mag skuif nie.

‡ Take note: If any of the Pulse options is selected, please initial next to the acknowledgements below. Due to the contracted designated service provider network pertaining to the Pulse options, I acknowledge and agree that my chosen unique benefit option is subject to the following:
Let wel: Indien enige Pulse opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die gekontrakteerde aangewese diensverskaffersnetwerk wat betrekking het tot die Pulse opsies, neem ek kennis en stem toe dat my gekose unieke voordeelopsie onderhewig is aan die volgende:

Initial / Parafeer

1. Primary care service provider network
1. Primêresorg diensverskaffersnetwerk

2. Specialist network
2. Spesialisnetwerk

3. Hospital network
3. Hospitaalnetwerk

Initial of applicant:
Paraaf van aansoeker:

3. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER) / ADRES EN KONTAKBESONDERHEDE (HOOFLID)

Email Address
E-pos adres

Telephone number (w)
Telefoonnommer (w)

Cell phone number
Selfoonnommers

Fax number
Faksnommer

Is your physical address the same as your postal address?
Is u fisiese adres dieselfde as u posadres?

Yes/Ja | No/Nee

Please take note that all future hard-copy correspondence will be sent to the postal address provided below.
Let wel dat alle toekomstige hardekopie korrespondensie gestuur sal word na die posadres soos onder verskaf

Physical Address Details/Fisiese adres besonderhede

Address
Adres

Street
Straat

Suburb
Voorstad

Town/City
Dorp/Stad

Postal Code
Poskode

Postal Address Details/ Pos adres besonderhede (Domicilium citandi et executandi)

Address
Adres

Street
Straat

Suburb
Voorstad

Town/City
Dorp/Stad

Postal Code
Poskode

Total member cards required
Aantal lidmaatskapkaarte benodig

Until receiving your membership card/s via post, you are able to download your e-card via the Bestmed app.
Tot tyd en wyl u lidmaatskap kaart/e u bereik, kan u gerus u e-kaart aflaai via die Bestmed-app.

4. THE FOLLOWING DOCUMENTS ARE COMPULSORY / DIE VOLGENDE DOKUMENTE IS 'N VEREISTE

If a child is older than 21, proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant. If a child is older than 21 and unemployed, a declaration statement is required and adult rates will apply.		As 'n kind ouer as 21 is, word 'n bewys van registrasie by 'n tersiêre instelling (tot op ouderdom van 26) verlang om as kinderafhanklike te kwalifiseer. Indien 'n kinder-afhanklike ouer as 21 jaar en werkloos is, word 'n beëdigde verklaring tot die effek benodig. Volwasse-afhanklike tariewe sal van toepassing wees.
In the case of extended family (parent, brother or sister only) - affidavit of dependant(s) with regards to dependency on principal member.		In die geval van uitgebreide familie (slegs ouer, broer of suster) - beëdigde verklaring van afhanklike(s) met betrekking tot afhanklikheid van hooflid.
Proof of previous medical scheme membership must be provided; this applies to members and all dependants (NB: Not a membership card). The aforesaid proof must contain the period and type of cover.		Bewys van Lidmaatskap van vorige mediese skemas; dit geld vir lede sowel as alle afhanklikes (LW: Nie 'n lidmaatskapkaart nie). Die bogenoemde bewys moet die soort en tydperk van dekking insluit.
In the case of a handicapped child dependant, a report from a medical practitioner.		In die geval van 'n gestremde kinderafhanklike, 'n verslag van 'n mediese praktisyn.

5. YOUR BANKING DETAILS / U BANKBESONDERHEDE

CLAIMS REFUND BANKING DETAILS / EISE TERUGBETALINGS BANKBESONDERHEDE

Bank
Bank

Branch
Tak

Branch code
Takkode

Type of account
Tipe rekening

Cheque/current
Tjek/lopende

Savings
Spaar

Account number
Rekeningnommer

Name of the account holder
Naam van Rekeninghouer

If account holder differs to Principal member, please confirm Account holder ID number
Indien die rekeninghouer verskil van die hooflid, bevestig asseblief rekening houer ID nommer

Signature of applicant/
Handtekening van aansoeker

Signature of account holder
(if different from applicant)/
Handtekening van getuie (indien
verskillend van aansoeker)

Initial of applicant:
Paraaf van aansoeker:

6. DEPENDANTS / AFHANKLIKES

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
1.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
2.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
3.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
4.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
5.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)
6.		M F	

Relationship/Verwantskap

Spouse / Gade ☐ Partner/Fiance/common law spouse *(complete declaration)* / Lewensmaat/verloofde/gemeenregtelike gade *(Voltooi verklaring)* ☐ Child *(if difference in surname, complete declaration)* / Kind *(Indien verskil in van, voltooi verklaring)* ☐

Other please specify: *(Affidavit/legal documents and proof of income required)*
Ander: Spesifiseer asseblief: *(Beëdigde verklaring/ wetlike dokumente en bewys van inkomste vereis)*

Dependant contact number
Afhanklike kontak nommer

7. PARTNERSHIP DECLARATION / VENNOOTSKAP VERKLARING

Only to be completed if you are registering a Partner/ Fiance/Common-law Spouse
Voltooi slegs as u 'n lewensmaat/ verloofde/gemeenregtelike gade registreer

I/ek

(principal member name and surname) declare that I have established a partnership with/(hooflid naam en van) verklaar dat ek 'n vennootskap gevestig het met

(your partner/fiance/common-law spouse name and surname) and that we have been living together since (u lewensmaat/verloofde/gemeenregtelike gade naam en van) en dat ons reeds saam woon sedert 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.

Ek verklaar dat ons van plan is om vir 'n onbepaalde tydperk saam te woon. Ek onderneem om Bestmed in te lig, binne 30 dae, van beëindiging van hierdie vennootskap.

Signed by me
Onderteken deur my

Signature of principal member/Handtekening van hooflid

on this
op die

day of
dag van

month/maand Y Y Y Y

8. CHILD DECLARATION / KINDER VERKLARING

Only to be completed if you are registering a child where the surname differs to the principal member
Voltooi slegs vir u kinder afhanklike wat u registreer, wie se van verskil van hooflid s'n

I/ek

(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.

(hooflid naam en van) verklaar dat (alle kinders wat se van verskil van hooflid) is my/my gade/my lewensmaat se biologiese kind.

1.
2.
3.
4.
5.
6.

Signed by me
Onderteken deur my

Signature of principal member/Handtekening van hooflid

on this
op die

day of
dag van

month/maand Y Y Y Y

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

* Die Skemareëls sal die toelating en die toepaslike tariewe bepaal.

9. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

Please note: Where the answer is YES, please give full details of the person concerned in the space provided. If you or any of your dependant(s) are suffering from a chronic condition, a medical report is required setting out details of the condition. If the space provided is insufficient, write the details on a separate page and attach it to this questionnaire. *The examples listed under each condition below is not intended as a full list of conditions, disorders or symptoms, but only serve as examples.*

Let wel: In die geval van 'n JA, moet die volle besonderhede van die betrokke persoon voorsien word in die beskikbare spasie. Indien u of enige van u afhanklikes aan 'n chroniese siektetoestand lei, word 'n mediese verslag benodig wat die besonderhede uiteensit. Indien die spasie wat voorsien word nie voldoende is nie, verskaf asseblief besonderhede op 'n afsonderlike bladsy en heg dit by hierdie vraelys aan. *Die voorbeelde wat onder by die toestande gelys is nie 'n volledige lys van toestande, versteurings of simptome nie, maar dien slegs as voorbeelde.*

Have you or any of your proposed beneficiary(-ies) received any medical advice, diagnosis, care or was recommended for treatment? Please clearly specify diagnosed condition in relevant tables. Non-disclosure of medical treatment/ conditions will result in your membership being terminated. Het u of u voorgestelde begunstigde(s) enige mediese behandeling of sorg, of advies rakende enige toestande ontvang? Dui asseblief duidelik die gediagnoseerde toestand aan in the verwante tabelle.	Indicate with an "X" (compulsory) Dui aan met 'n "X" (verpligtend)		Name of patient Naam van pasiënt	Date diagnosed Datum gediagnoseer	Last treatment date Laaste datum van behandeling	Level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation Graad/stadium van siekte toestand, aard van behandeling, medisyne, dosis en hospitalisasie
1. Congenital physical deviations e.g. bat ears, valvular heart disease Kongenitale fisiese afwykings bv. bakore, hartklepsiektes	Yes / Ja	No / Nee				
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis, acne Velabnormaliteit (insluitende allergieë) bv. ekseem, psoriase, aknee	Yes / Ja	No / Nee				
3. Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems Skelet-, gewrigs- en spierafwykings en probleme bv. artritis, rugprobleme	Yes / Ja	No / Nee				
4. Sensory organs: sight, hearing, speech, also state spectacles and/or contact lenses Sintuie: sig, gehoor, spraak, meld brille en/of kontaklense	Yes / Ja	No / Nee				
5. Respiratory system e.g. asthma, COPD Siektes van die lugweë bv. asma, KOLS	Yes / Ja	No / Nee				
6. Cardio-vascular systems e.g. hypertension, high cholesterol, heart failure, thrombosis Siektes van die kardiovaskulêre stelsel bv. hipertensie, hoë cholesterol, hartversaking, trombose	Yes / Ja	No / Nee				
7. Digestive system e.g. hiatus hernia, stomach ulcer, spastic colon, gallstones Spysverteringstelselsiektes bv. hiatus hernia, maagseer, spastiese kolon, galstene	Yes / Ja	No / Nee				
8. Urinary system, e.g. kidney problems (infections, failure, dialysis, stones) or bladder problems (infection, incontinence) Urienwegsisteem, bv. nierprobleme (infeksies, versaking, dialise en stene) of blaasprobleme (infeksie, inkontinensie)	Yes / Ja	No / Nee				
9. For Males only / Alleenlik op Manlikke begunstigdes						
Male reproductive system, e.g. prostate and testes problems Manlike reproduktiewe sisteem, bv. prostaat- en testesprobleme	Yes / Ja	No / Nee				
Hormone system e.g. hormone replacement therapy Hormoonstelsel bv. hormoonvervangingsterapie	Yes / Ja	No / Nee				
10. For Females only / Alleenlik op vroulike begunstigdes						
Pregnancy or suspected pregnancy Swanger of vermoede van swangerskap	Yes / Ja	No / Nee				
Female reproductive system, e.g. endometriosis, menstrual problems and infertility Vroulike reproduktiewe sisteem, bv. endometriose, menstruele probleme en onvrugbaarheid	Yes / Ja	No / Nee				

Initial of applicant:
Paraaf van aansoeker:

11. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems Metaboliese siektes bv. vetsug, diabetes, porfirie, skildklierprobleme	Yes / Ja	No / Nee				
12. Psychiatric or psychological treatment e.g. depression, anxiety, sleeping disorders, counselling Psigiatriese of sielkundige behandeling bv. depressie, angs, slaapversteurings, beranding	Yes / Ja	No / Nee				
13. Nervous system e.g. paralysis, epilepsy, Parkinson's disease, headaches, stroke Senuweestelselsiektes bv. Verlamming, epilepsie, Parkinson se siekte, hoofpyne, beroerte	Yes / Ja	No / Nee				
14. Substance dependence e.g. alcohol, drugs, rehabilitation Middelafhanklikheid bv. alkohol, dwelms, rehabilitasie	Yes / Ja	No / Nee				
15. Have you ever been diagnosed with cancer, a growth or tumour of any kind? Please state type and date. Is kanker, 'n vergroeisel of gewas van enige soort ooit voorheen by u gediagnoseer? Spesifiseer tipe en datum.	Yes / Ja	No / Nee				
16. Dental treatment Tandheelkundige behandeling	Yes / Ja	No / Nee				
17. Ear, Nose and throat related treatment, e.g. grommets, nasal surgery, tonsils Oor, neus en keel behandeling, bv. oorpypies, neus chirurgie, mangels	Yes / Ja	No / Nee				
18. Operations undergone. Please state type and date. Operasies ondergaan. Spesifiseer tipe en datum.	Yes / Ja	No / Nee				
19. Are you and/or your dependant(s) currently being treated for a medical condition or symptoms not stipulated above? Word u en/of u afhanklike(s) tans vir 'n mediese toestand of simptome behandel wat nie bo vermeld word nie?	Yes / Ja	No / Nee				
20. Current medication used, not yet stated above Huidige medisyne wat gebruik word en nog nie hier bo gemeld is nie	Yes / Ja	No / Nee				
21. Contagious diseases e.g. positive for HIV/AIDS*, hepatitis B, tuberculosis Oordraagbare / aansteeklike siektes bv. positief vir MIV/VIGS*, hepatitis B, tuberkulose	Yes / Ja	No / Nee				

***** 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.

***** Indien u en/of enige van u afhanklikes MIV-positief is, of VIGS het en verkies om nie u en/of hul MIV-status op hierdie vorm te meld nie, weens vertroulikheid, moet u 012 472 6249 skakel of 'n e-pos stuur na mhc@bestmed.co.za om Bestmed in kennis te stel van u en/of u afhanklike(s) dat u en/of u afhanklikes met MIV/Vigs saamleef. Hierdie inligting moet binne sewe (7) werksdae vanaf die datum van u aansoek vir u en/of u afhanklike(s) se lidmaatskap aan Bestmed gemeld word. By ontvangs van die versoek sal Bestmed bepaal of onderskrywingstoestande toegepas sal word, en indien dit die geval is, sal u 'n dokument met 'n gewysigde bewys van lidmaatskap ontvang.

22. 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 'n Toestand waarvoor u en/of u afhanklike(s) 'n uitbetaling en/of gewaarborgde mediese behandeling van welke aard ookal ontvang het, bv. derdeparty eis	Yes / Ja	No / Nee				
23. Any other medical condition not mentioned above, even though you or your dependant(s) did not receive treatment or advice, or consult a doctor in the past 12 months? Enige ander mediese aangeleentheid wat nie hierbo gemeld is nie, selfs al het u of u afhanklike(s) nie behandeling of advies ontvang, of 'n dokter gekonsulteer in die laaste 12 maande nie?	Yes / Ja	No / Nee				

Initial of applicant:
Paraaf van aansoeker:

24. Are you or any of your dependant(s) expecting any planned surgery/ hospitalisation/treatment within the next 12 months? Verwag u of enige van u afhanklike(s) om beplande chirurgie/hospitalisasie/ behandeling binne die volgende 12 maande te ontvang?	Yes / Ja	No / Nee				
Please note: If you are currently using chronic medicine, also complete the separate chronic application form available on the website, or call 086 000 2378. **Let wel: Indien u tans chroniese medisyne gebruik, voltooi ook die afsonderlike chroniese aansoekvorm wat beskikbaar is op die webwerf, of skakel 086 000 2378.**						

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. The Medical Schemes Act makes provisions for a membership to be terminated where non-disclosure of material information is proven and the law does not recognise ignorance as an excuse. 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.

Belangrik: Dit bly die verantwoordelikheid van die aansoeker om die vereiste inligting ten opsigte van alle afhanklikes en/of die aansoeker, volledig openbaar te maak. Indien u wil, is u welkom om 'n mediese verslag, van u gesins praktisyn, by te voeg. Die Wet op mediese skemas bepaal dat die Skema die reg het om lidmaatskap te beëindig indien nie alle vereiste inligting openbaar gemaak was nie. Onkunde sal nie as geldige verskoning aanvaar word nie. U handtekening op die aansoekvorm dui aan, onder andere, dat u die terme en voorwaardes van lidmaatskap verstaan, en dat die inligting in die aansoekvorm verskaf, waar en korrek is. Indien u onseker is oor enige van die vrae, moet asseblief nie huiwer om Bestmed se kontak sentrum te kontak nie.

I/ek

(principal member name and surname) declare that all information declared above is true and correct.
(hooflid naam en van) verklaar dat alle inligting, soos hierbo verklaar, is waar en korrek.

Signed by me
Onderteken deur my

Signature of principal member/Handtekening van hooflid

on this
op die

day of
dag van

month/maand Y Y Y Y

Initial of applicant:
Paraaf van aansoeker:

10. PREVIOUS MEMBERSHIP STATUS / VORIGE LIDMAATSKAPSTATUS

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

Verskaf asseblief vorige lidmaatskap sertifikate, van 'n Suid-Afrikaanse geregistreerde mediese skema, as bykomende bewyse van vorige mediese fonds dekking. Hierdie voorlegging van vorige mediese sertifikate sal verseker dat korrekte en toepaslike onderskrywing op jou nuwe profiel geplaas word.

Have you and/or your spouse/partner and/or dependant(s) been a member(s) or dependant(s) of a medical scheme(s)? Was u en/of u gade/metgesel en/of afhanklike(s) 'n lid/afhanklike van 'n mediese skema(s)?	Yes/ Ja	No/ Nee

If "yes" attach termination certificate
Indien "ja" heg beëindigingsertifikaat aan

Name of scheme Naam van skema	Member number Lidmaatskapnommer	Principal member Hooflid	Dependant Afhanklike	Date from Datum vanaf	Date to Datum tot

It is important to note that proof of previous membership may prevent possible waiting periods being imposed:
Dit is belangrik om daarop te let dat bewys van vorige lidmaatskap, moontlike wagtydperke kan voorkom:

Bestmed will do NO risk underwriting in respect of staff of participating employers who apply for registration as principal members within 90 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 (during this general waiting period no claims will be funded by the Scheme)
- 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 **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.

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.

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.

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

Late joiner penalties can be imposed on extended family over the age of 35. Depending on the number of years the dependant did not belong to a medical scheme, a late joiner penalty will be added to the dependant's monthly 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 dependant did not belong to a medical scheme.

Laataansluitingsboete (in gevolge Regulasie 131 van die Wet op Mediese Skemas (Wet 131 van 1998))

Laataansluitingsboetes kan op uitgebreide gesin wat ouer as 35 jaar is gehef word. Afhangende van die aantal jare waartydens die afhanklike nie aan 'n mediese skema behoort het nie, sal 'n laataansluitingsboete by die maandelikse bydrae gevoeg word. Die boete word bereken op 'n glyskaal soos uiteengesit in die onderstaande tabel en word gebaseer op die totale aantal jare ná die ouderdom van 35 effektief 1 April 2001, waartydens die afhanklike nie aan 'n mediese skema behoort het nie.

11. HEALTHCARE ADVISOR DECLARATION / GESONDHEIDSORGADVISEUR SE VERKLARING

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.

1) Ek verklaar dat ek 'n geakkrediteerde Bestmed gesondheidsorg adviseur is, ek is geregistreer as 'n adviseur ingevolge die Wet op Finansiële Advies- en Gesondheidsorgadviesdienste 37 van 2002 en 'n geakkrediteerde makelaar ingevolge gedeelte 65 van die Wet op Mediese Skemas is.

2) Ek aanvaar dat die aansoeker my aangestel het as sy/haar gesondheidsorgadviseur en dat hy/sy daarop geregtig is om my dienste te beëindig.

3) Ek bevestig dat die aansoeker my persoonlike besonderhede, insluitend my fisiese en posadres, sowel as my telefoonnommer ontvang het.

4) Ek verklaar dat ingevolge Wet 131 van 1998 van die Wet op Mediese Skemas (of soos gewysig), 'n maandelikse statutêre kommissie aan my uitbetaal sal word, tot en met 'n maksimum bedrag soos vasgestel deur die Wet op Mediese Skemas.

5) Ek erken dat daar geen wanvoorstelling van enige feite deur my is nie en dat in die geval van materiële of onwettige optrede, ek verantwoordelik sal wees vir die terugbetaling van alle gelde wat betaal is in die effek van so 'n wanvoorstelling.

6) Ek verklaar dat die aansoeker bekend is met die inligting wat benodig word in die aansoekvorm en dat hy/sy al die korrekte inligting verskaf het.

7) Ek verklaar dat die raad en ondersteuning wat gegee is aan die aansoeker onbevooroordeeld en in sy/haar beste belang is.

8) Ek verklaar dat die aansoeker persoonlik hierdie aansoekvorm onderteken het.

12. SUMMARY OF MONTHLY COST / OPSOMMING VAN MAANDELIKSE KOSTES

1. Total high risk premium (principal member or principal member and spouse/partner and child dependant/s)
Totale hoë-risiko premie (hooflid of hooflid en gade/metgesel en kinderafhanklike(s))

R | | | | | | | | . | | |

2. Total monthly medical savings account
Totale maandelikse mediese spaarrekening

R | | | | | | | | . | | |

3. Extended family (including monthly savings)
Uitgebreide familie (ingesluit maandelikse spaarrekening)

R | | | | | | | | . | | |

MONTHLY TOTAL (1-3)
TOTALE MAANDELIKSE KOSTE (1-3)

R | | | | | | | | . | | |

Healthcare advisor name
Naam van gesondheidsorgadviseur

A	r	t	h	u	r		E	a	s	t	o	n							

Healthcare advisor code
Gesondheidsorgadviseurskode

A	B	E	N	0	1	A	1	K	J	D	T

Healthcare advisor signature/Handtekening van gesondheidsorg-adviseur

Datum
Date

D	D	M	M	Y	Y	Y	Y

Initial of applicant:
Paraaf van aansoeker:

13. STATEMENT OF APPLICANT / VERKLARING DEUR AANSOEKER

I/ek

hereby declare that: / verklaar dat:

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

b. 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);

c. 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;

d. 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;

e. 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;

f. If after 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, 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;

g. Any deterioration or change in my state of health or in that of any 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 or declare the membership null and void in which case all monies paid to Bestmed in connection with this membership before Bestmed is informed of the change, shall be forfeited and benefits paid by Bestmed shall immediately be refunded to Bestmed;

h. Bestmed reserves the right to cancel membership should it become apparent that false information was wilfully supplied on this application.

i. 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.

j. I hereby consent to my personal health information being processed by Bestmed for the purpose of determining my medical risk profile and to my information being further processed by any managed healthcare partner, loyalty benefits partners or any separate entities that provide health-related services independently, or on behalf of Bestmed, for inter alia the purpose of:

- selecting beneficial wellness programme options on behalf of the members;
- allowing agents of such managed healthcare partners, loyalty benefits administrators or independent entities to determine the optimal products and services to be offered to Bestmed members;
- offering said options, products and services to members with their prior consent.

I hereby affirm that I am aware that the processing of my personal health information is a mandatory requirement for the existence of a valid medical insurance agreement between the parties and that I am aware of my right to object to the processing and/or further processing of my personal information and of my right to lodge a complaint to the information regulator.

a. Indien ek as lid van Bestmed ingeskryf word, ek my aan die reëls van Bestmed sal onderwerp;

b. Die inligting hierin na die beste van my wete en oortuiging volkome waar is en dat ek geen inligting verswyg het nie. Ek aanvaar dat die mediese spaarrekening pro rata bereken word (waar van toepassing);

c. Ek verstaan dat indien my aansoek om lidmaatskap goedgekeur en aanvaar word, die inligting vervat in my aansoekvorm in die toekoms die basis sal vorm van my aansoek en die betaling van voordele;

d. Ek gee onherroeplik toestemming aan enige geneesheer, persoon of instansie wat in besit mag wees of in besit mag kom van inligting aangaande my gesondheid of dié van my afhanklike(s), om die inligting aan Bestmed of sy gevolmagtigde te openbaar, ook na my dood of dié van my afhanklike(s). Ek verstaan dat die inligting tesame met ander inligting in ag geneem sal word met die evaluasie van betalings ten opsigte van sekere mediese toestande. Ek waarborg dat ek my afhanklike(s) se toestemming verkry het om hierdie magtiging te verleen;

e. Ek onderneem om my bydrae op rekeninge aan Bestmed te vereffen en by versuim magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my salaris af te trek, of indien ek sou bedank, magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my pensioen of enige ander gelde aan my betaalbaar af te trek en aan Bestmed oor te betaal;

f. Indien daar na my toelating as lid van Bestmed gevind word dat enige verklaring of inligting deur my verstrek, willens en/of wetens onvoldoende of onwaar was, ek toestem om alle betalings wat Bestmed namens my gemaak het, ten volle terug te betaal en om alle aanspreeklikheid op enige voordele aan die kant van Bestmed, te verbeur;

g. Enige verswakking of verandering in my gesondheidstoestand of in dié van my afhanklikes voor die datum of gebeurtenis wat deur Bestmed vir die aanvang van lidmaatskap gestel sal word, of die datum van die aanvaarding van hierdie aansoek deur Bestmed, of die datum van ontvangs van die eerste ledegelde, watter een ookal laaste is, Bestmed die reg sal gee om die aansoek te heroorweeg en nuwe voorwaardes vir toelating voor te stel of die lidmaatskap nietig te verklaar, in welke geval alle gelde wat ten opsigte van hierdie lidmaatskap aan Bestmed betaal is voordat Bestmed kennis van die verandering ontvang het, verbeur word en uitbetaalde voordele onverwyld aan Bestmed terugbetaal sal word;

h. Bestmed behou die reg om lidmaatskap onverwyld te kanselleer indien dit aan die lig sou kom dat valse inligting willens en wetens met hierdie aansoek verskaf is.

i. Ek is bewus daarvan dat die datum van my aansoek nie noodwendig verwys na die datum van my toelating as 'n Bestmed-lidmaat nie en dat die toelatingsdatum so spoedig moontlik deur Bestmed aan my gekommunikeer sal word.

j. Ek gee hiermee toestemming dat my persoonlike gesondheidsinligting deur Bestmed verwerk mag word met die doel om my mediese risikoprofiel te bepaal en dat my inligting verder verwerk mag word deur enige bestuurdesorgvennoot, lojaliteitsprogramvennoot of enige afsonderlike entiteit wat gesondheidsverwante dienste onafhanklik aanbied, of namens Bestmed inter alia vir die doel om:

- voordelige gesondheidsorgprogramme namens die lede te verkies;
- sodat agente van sodanige gesondheidsorgprogramme, administrateurs van lojaliteitsvoordele of onafhanklike entiteite die optimale dienste en produkte mag bepaal wat aangebied gaan word aan Bestmed-lede;
- dat die bogemelde opsies, produkte en dienste aangebied mag word aan die lede wat hul toestemming vooraf daarvoor gegee het.

Ek bevestig hiermee dat ek daarvan bewus is dat die verwerking van my persoonlike gesondheidsinligting 'n verpligte vereiste vir die bestaan van 'n geldige mediese versekeringsooreenkoms tussen die partye is, en dat ek bewus is van my reg om teen die verwerking en/of verdere verwerking van my persoonlike inligting beswaar te mag maak, en op my reg om 'n formele klag te mag lê by die inligtingsreguleerder.

Signature of applicant/Handtekening van aansoeker

Signature of witness/Handtekening van getuie

Signed at / Geteken te

on this / op die

day of / dag van

month/maand Y Y Y Y

Initial of applicant: / Paraaf van aansoeker: