

INDIVIDUAL APPLICATION FORM



1. APPLICANT (PRINCIPAL MEMBER)

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

2. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	<input type="checkbox"/>	Beat1N (Network) †	<input type="checkbox"/>	Pace1	<input type="checkbox"/>	Pulse1 * ‡	<input type="checkbox"/>
Beat2	<input type="checkbox"/>	Beat2N (Network) †	<input type="checkbox"/>	Pace2	<input type="checkbox"/>	Pulse2 ‡	<input type="checkbox"/>
Beat3	<input type="checkbox"/>	Beat3N (Network) †	<input type="checkbox"/>	Pace3	<input type="checkbox"/>		
Beat4	<input type="checkbox"/>			Pace4	<input type="checkbox"/>		

Income bracket if you are joining on the Pulse1 Option

R 0 - R 5 500 monthly	R 5 501 - R 8 500 monthly	R 8 501 and above monthly
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* 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 interval, pending proof of income.

† Take note: If any of the BeatN options are 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:	Initial
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.	

‡ Take note: If any of the Pulse options are 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:	Initial
1. Primary care service provider network	
2. Specialist network	
3. Hospital network	

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.

4. SUMMARY OF MONTHLY COST

Failure to complete the below section in full will result in unsuccessful broker commission payments

1. Total high risk premium (principal member or principal member and spouse/partner and child dependant/s) R
 2. Total monthly medical savings account R
 3. Extended family (including monthly savings) R
- MONTHLY TOTAL (1-3)** R

Healthcare advisor name

Healthcare advisor code

Healthcare advisor signature

Date

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Telephone number (w) Fax number

Telephone number (h) Cellphone number

Is your home address the same as your postal address? Yes No

Please take note that all future hard-copy correspondence will be sent to the postal address provided below.

Home address details

Address

Street

Suburb

Town/city Postal code

Postal address details (Domicilium citandi et executandi)

Address

Street

Suburb

Town/city Postal code

Until receiving your membership card/s via post, you are able to download your e-card via the Bestmed app.

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	20 th	25 th	1 st
Bank			
Branch			
Branch code		Type of account	Cheque/current Savings
Account number			
Select account holder	Member	Company	Other

If you have selected "OTHER" please complete below section in accordance with SARS legislative requirements where account holder differs from the principal member:

Title			
First name			
Middle name		Initials	
Surname			
Name of company (Complete only if selected above)			
Account holder ID number			
Passport number (for non-SA citizens)			
Country of issue			
SARS tax number		Date of birth	D D M M Y Y Y Y
Home address			
		Postal code	
Is your home 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
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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 sum of the **amount below** 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.

TOTAL MONTHLY CONTRIBUTION R

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

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

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

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

If other, please specify relationship: (affidavit/legal documents and proof of income required) _____

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

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

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

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

If other, please specify relationship: (affidavit/legal documents and proof of income required) _____

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

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

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

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

If other, please specify relationship:

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

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

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

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

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

If other, please specify relationship:

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

5. Dependant details

First name

Surname

ID number (passport number for non-SA citizens) Gender M F

Country of issue Date of birth D D M M Y Y Y Y

SARS tax number

Dependant contact number

Email address

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

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

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

If other, please specify relationship:

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

6. Dependant details

First name, Surname, ID number (passport number for non-SA citizens), Gender (M, F), Country of issue, Date of birth (D, D, M, M, Y, Y, Y, Y), SARS tax number, Dependant contact number, Email address

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

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

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

If other, please specify relationship: (affidavit/legal documents and proof of income required)

8. PARTNERSHIP DECLARATION

Only to be completed if you are registering a partner/fiancé/common-law spouse

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 rules of the Scheme 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:

The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a Dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application:

- A general waiting period of up to 3 (three) months;
- A condition-specific waiting period of up to 12 (twelve) months.

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:

- A condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits; or
- In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application.

- A general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

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

Monitor for possible non-disclosure

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

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

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

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

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

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

Late joiner penalties can be imposed on beneficiaries over the age of 35. Depending on the number of years the beneficiary did not belong to a medical scheme, a late joiner penalty will be added to the members monthly risk contribution. The penalty is calculated on a sliding scale as shown in the table below, based on the total number of years from age 35 being effective 1 April 2001, where a beneficiary did not belong to a medical scheme.

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

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(s) or dependant(s) of a medical scheme(s)?

Yes	No
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If "yes" please attach all previous membership certificates

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

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12. MEDICAL QUESTIONNAIRE

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.*

Have you or any of your proposed beneficiary-(ies) received any medical advice, diagnosis, care or was recommended for treatment for the following, within the 12 month period ending on the date on which you are applying for membership. Please clearly specify the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Date diagnosed	Last treatment date	Level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation
	Yes	No				
1. Congenital physical deviations e.g. bat ears, valvular heart disease	Yes	No				
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis, acne	Yes	No				
3. Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems	Yes	No				
4. Sensory organs: sight, hearing, speech, also state spectacles and/or contact lenses	Yes	No				
5. Respiratory system e.g. asthma, COPD	Yes	No				
6. Cardio-vascular systems e.g. hypertension, high cholesterol, heart failure, thrombosis	Yes	No				
7. Digestive system e.g. hiatus hernia, stomach ulcer, spastic colon, gallstones	Yes	No				
8. Urinary system, e.g. kidney problems (infections, failure, dialysis, stones) or bladder problems (infection, incontinence)	Yes	No				
9. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems	Yes	No				
10. Psychiatric or psychological treatment e.g. depression, anxiety, sleeping disorders, counselling	Yes	No				
11. Nervous system e.g. paralysis, epilepsy, Parkinson's disease, headaches, stroke	Yes	No				
12. Substance dependence e.g. alcohol, drugs, rehabilitation	Yes	No				
13. Have you ever been diagnosed with cancer, a growth or tumour of any kind? Please state type and date.	Yes	No				
14. Dental treatment	Yes	No				

