NEDBANK APPLICATION FORM (SHORTENED VERSION)



1. APPLICANT (I	PRIN	CIPA	L MI	EME	BER)																		
Title										В	estme	d join d	ate			D	D	М	М	Υ	Υ	Υ	Υ
First name																							
Middle name																			Initials				
Surname																							
ID number													Dat	te of bir	th	D	D	М	М	Υ	Υ	Υ	Υ
Home language																							
Passport number																				Ge	ender	M	F
Country of issue (passp	ort)																						
SARS tax number (SAI	RS legis	slative r	require	ment)																			
Marital status	Unm	arried	Ma	ırried		Date o	f marri	iage/div	vorce		D	D	М	М	Υ	Υ	Υ	Υ					
Date of employment	D	D	M	M	Y	Υ	Υ	Υ		Unio	que nu	mber											
2. BENEFIT OPT	ION																						
Benefit option (indica	to with	h (Y/)																					
Beat1		X		Г	Beat1	J (Noty	ork) +					ace1						DH	ythm1	* +			
Beat2					Beat2														ythm2				
Beat3				-	Beat3					Pace2									19 (111112	т			
Beat3 Plus				L		,	,,			Pace4													
Beat4																	_						
Income bracket if you	are jo	ining o	n the F	₹hythr	m1 Opt	ion			Inc	ome bi	acket	if you a	re join	ing on	the Rh	ythm2	Option	n					
R 0 - R 9 000 monthly	F	R 9 001 m	- R 14 onthly			R 14 and a mon	oove				R 5 5 onthly		R	5 501 - mon		00	a	R 8 50 nd abo month	ve				
* Provide proof of inc Please note that you											ıs).												
† Members on any of	the Be	atN op	tions e	enjoy :	an effic	iency d	iscoun	t. By se	electing	g one o	f the E	BeatN o	ptions	you ac	knowle	edge aı	nd agre	e to th	ne follo	wing c	onditio	ns:	
1. I am limited to a h													-	-									
2. I am aware of the	locatio	n of th	e near	est ab	ove-me	ntione	d netw	ork hos	pital pr	ovider	5.												
3. If I willingly do no	t make	use of	the afo	oresai:	d netwo	ork prov	iders, l	am aw	are and	d agree	that I	will be	held lia	able for	а со-р	aymen	t in ter	ms of t	the Sch	eme R	ules.		
4. I am aware that t	nis is a	unique	benefi	it opti	on and t	hat I m	ay not	, in tern	ns of th	ne Sche	me Ru	ıles, cha	inge fr	om a B	eatN o _l	otion to	a star	ndard E	Beat op	tion du	ring the	e year.	
* Members on a Rhyt					to the c	ontract	ed Rhy	/thm de	esignat	ed ser	vice pr	ovider	netwo	rk. By s	electir	ng a Rh	ythm o	ption	you acl	nowle	edge an	d agre	e
1. Primary care serv																							
2. Specialist networ	· ·																						
3. Hospital network																							

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. ADDRESS AND	ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)																						
Email address																							
Linai address											1												
Telephone number (w)												x numb											
Telephone number (h)												llphone mber											
Is your home address the	e sam	e as yo	ur pos	tal add	ress?			Yes		Vo													
Home address details											,												
Town/city																		Postal	code				
Postal address details (I	Domic	ilium (itandi	et exe	cutand	i)				-				-	-		1						
Town/city																		Postal	code				
Please download the Bes	stmed	App fo	or acce	ss to yo	ur digi	tal mer	nbersh	ip card	on dat	e of re	gistrati	on, and	look o	ut for a	n SMS	with a	」 link aft	er regis	stration	has be	en con	pleted	l.
/ UENITUGADE /	ease 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. HEALTHCARE ADVISOR DECLARATION																						
4. HEALTHCARE	HEALTHCARE ADVISOR DECLARATION																						
1. I declare that I am an	accre	dited B	estme	d healt	hcare a	dvisor,	I am a	registe	red adv	risor in	terms	of the Fi	inancia	ıl Advis	ory and	l Intern	nediary	Service	es Act 3	37 of 20	002 to s	sell Hea	alth
Service Benefits, and	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.																						
	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. Lacknowledge 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 as set by the Medical Schemes Act.															num an	nount						
5. I declare that there h in effect of such misr						any fa	ct by m	ne and	that, ir	the ev	ent of	materia	ıl or un	lawful	condu	ct, I will	be res	ponsib	le for re	efundir	ng all m	onies p	oaid
6. I declare that the app	licant	is fam	niliar w	ith the	inform	ation r	equired	l in the	applic	ation fo	orm and	d he/sh	e has p	orovide	d all th	e corre	ct infor	mation	n.				
7. I declare that the adv	rice ar	nd supp	oort giv	en to t	he app	licant v	was un	biased	and in	his/he	r best i	nterest.											
8. I declare that the app	licant	has p	ersona	lly sign	ed this	applica	ation fo	orm.															
5. SUMMARY OF I	NON	ITHL	Y CO	ST																			
Failure to complete the I	below	section	on in fu	ıll will	result	in unsu	iccessf	ul brol	cer con	nmissi	on payı	ments											
1. Total high risk premium	(princ	ipal me	ember	or princ	ipal me	mber a	nd spo	use/pa	rtner aı	nd child	depen	dants)		R									
2. Total monthly medical	savin	gs acc	ount											R									
3. Extended family (include	ding n	nonthl	y savin	gs)										R									
MONTHLY TOTAL (1-3)														R									
Healthcare advisor name	. [
Healthcare advisor code																							
														Dat	_	Б				V	٧/		

Healthcare advisor signature

5. YOUR BAI	NKING DETAILS																								
CLAIMS REFU	JND B	ANKIN	IG DET	AILS	5																				
Bank																									
Branch																	В	Branch (code						
Type of account	(heque/	current	t	Ç.	Saving	gs		Accou	unt nui	mber [
Name of the acco	ount ho	lder																							
If account holde holder's ID num		s from	principa	al mei	mber	r, pleas	se conf	irm ac	count																
Signature of app																									
7. PARTNER							150	-,																	
Only to be comp	pleted	if you a	re regis	terin	ng a p	oartne	r/fianc	e/com	mon-	law s	pouse w	ith a s	urname	that	is differ	ent to t	hat of	the ma	ain mei	mber.					
I, principal m	nember	name	and sur	name	e) de	clare t	hat I h	ave es	tablisl	hed a	partners	hip wi	th												
(your partn	er/fian	cé/com	mon-la	ıw sp	ouse	e name	e and s	urnam	ie) and	d that	we have	e been	living t	ogeth	er since			D	D	M	М	Υ	Υ	Υ	Υ
	(your partner/fiancé/common-law spouse name and surname) and that we have been living together since																								
I declare that v	we inte	nd to c	ontinue	livin	g tog	gether	indefir	nitely, a	and I u	undert	take to i	nform	Bestme	ed wit	hin 30 d	lays in t	the eve	ent of t	ermina	ition of	this pa	artners	hip.		
Signed by me											on th	is			day	of			montl	h		Υ	Υ	Υ	Υ
	Signat	ure of p	orincipa	ıl mer	mber	r																			
B. CHILD DE	CLA	RATIO	ON																						
Only to be com	pleted	if you a	ire regi:	steri	ng a	child	where	the su	rnam	e diffe	ers to th	e prin	cipal m	embe	r										
l,																									
(principal memb	per nan	ne and	surnam	e) de	clare	e that	(all chil	dren w	here :	surna	me's dif	fers to	princip	al me	mber) is	my/m	y spous	se/my	partne	r(s) bio	logical	child.			
1.																									
2.																									
3.																									
4.																									
																				1					
5.																									

Signature of principal member

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

1. Dependan	t details																							
First name																								
Surname																								
ID number (pas	sport numb	er for	non-SA	citizen	s)																Ge	nder	М	F
Country of issue	(passport)													D	ate of	birth	D	D	М	М	Υ	Υ	Υ	Υ
SARS tax numb	oer																							
Dependant cor	itact num	ber												lations ncipal i	hip to membe	er:								
Email address																								
Provision of co	ontact inj	orm	ation f	or you	ır depe	endant	older	than 1	8 year	s will a	llow B	estme	d to coi	mmun	icate c	hronic	inform	nation	directi	y to th	e appl	icable (depen	dant/s
2. Dependan	t details																							
First name																								
Surname																								
ID number (pas	sport numb	er for	non-SA	citizen	s)																Ge	nder	М	F
Country of issue	(passport)													D	ate of	birth	D	D	M	M	Υ	Υ	Υ	Υ
SARS tax numb	oer																							
Dependant cor	ntact num	ber												lations	hip to	ar.								
Email address														ПСТРОТТ	Incinibe									
Provision of co	ontact inj	orm	ation f	or you	ır depe	endant	older	than 1	8 year	s will a	llow B	estme	d to coi	mmun	icate c	hronic	inform	nation	directl	ly to th	e appl	icable (depen	dant/s
3. Dependan	t details																							
3. Dependant	t details																							
	t details																							
First name			non-SA	citizen:	s)																Ge	nder	M	F
First name Surname	sport numb		non-SA	citizen:	s)									D	ate of I	birth	D	D	M	M	Ge	nder	M	F
First name Surname ID number (pass	sport numb		non-SA	. citizen:	s)									D	ate of I	birth	D	D	M	M				
First name Surname ID number (pass) Country of issue	sport numb (passport)	er for	non-SA	citizen:	s)									ations	hip to		D	D	M	M				
First name Surname ID number (pass Country of issue SARS tax numb	sport numb (passport)	er for	non-SA	citizen:	s)									ations			D	D	M	M				
First name Surname ID number (pass Country of issue SARS tax numb Dependant con	sport numb (passport) per	er for				endant	older	han 1	8 years	s will d	lllow Bo	eestmee	prii	ations ncipal r	hip to membe	er:					Y	Y	Y	Y
First name Surname ID number (pass) Country of issue SARS tax numb Dependant con Email address	(passport) per stact numl	er for				endant	older	han 1:	8 years	s will d	lillow Be	eestmee	prii	ations ncipal r	hip to membe	er:					Y	Y	Y	Y
First name Surname ID number (pass Country of issue SARS tax numb Dependant con Email address Provision of co	(passport) per stact numl	er for				endant	older	han 1:	8 years	s will d	lillow Be	eestmee	prii	ations ncipal r	hip to membe	er:					Y	Y	Y	Y
First name Surname ID number (pass) Country of issue SARS tax numb Dependant con Email address Provision of co	(passport) per stact numl	er for				endant	older	than 1	8 years	s will d	lllow Be	eestmee	prii	ations ncipal r	hip to membe	er:					Y	Y	Y	Y
First name Surname ID number (pass) Country of issue SARS tax numb Dependant con Email address Provision of co 4. Dependant First name	sport numb (passport) per stact numl contact inj	er for	ation f	ior you	ir depe	endant	older	ihan 1	8 years	s will d	lllow Bd	eestmee	prii	ations ncipal r	hip to membe	er:					Y e appl	Y	Y	Y
First name Surname ID number (pass Country of issue SARS tax numb Dependant con Email address Provision of co 4. Dependant First name Surname	sport numb (passport) per stact numl t details	er for	ation f	ior you	ir depe	endant	older	than 1	8 year	s will d	lllow Bd	eestmee	prii	iations ncipal r	hip to membe	hronic					Y e appl	Y icable	Y	Y
First name Surname ID number (passed of the passed of th	(passport) t details sport numb (passport)	er for	ation f	ior you	ir depe	endant	older	than 1	8 year	s will d	Illow Bu	eestmee	prii	iations ncipal r	hip to membe	hronic	inform	nation	directi	ly to th	y e appl	Y Y	Y dependent	Y Y
First name Surname ID number (pass) Country of issue SARS tax numb Dependant con Email address Provision of co 4. Dependant First name Surname ID number (pass) Country of issue	(passport) t details sport numb (passport) contact inj t details (passport)	er for	ation f	ior you	ir depe	endant	older	than 1	8 year	s will d	Illow Ba	eestmee	prin	mmun.	icate of I	hronic	inform	nation	directi	ly to th	y e appl	Y Y	Y dependent	Y Y

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

9. DEPENDANTS TO BE ADDED

10. 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
 - 2.12 To analyse my Personal Information collected for research and statistical purposes.
 - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
 - 2.14 To carry out analysis and profiling of my membership profile.
- 3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No
Signature of	applicant

11. STATE	MENT O	F API	PLICA	INT																				
I,																								
hereby declarules and re		-			-	applicat	ion for	m, I aş	gree to	the te	rms and	d condi	tions of	Bestn	neds n	nembei	rship re	gistra	tion an	d adhe	re to th	ne		
To be compl	_																							
Signature of	applicant																							
Signed at											on t	his		da	ıy of			mont	:h		Υ	Υ	Υ	Υ
12. STATE	MENTB	Y EM	PLOY	ER																				
To be comple	eted by Emp	loyer (<i>P</i>	LL FIEI	.DS CO	MPUL	SORY)																		
We (employe	er name)																							

- 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 and/or Special Personal Information and/or that of our employees and their spouse(s), children and or other dependant third parties ("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
- 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
- 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. Signature of employer HR practitioner details Surname Full names E-mail Telephone number State that the applicant a. Has been **permanently** employed by us since D D M M Υ b. Bestmed membership to start D D M M c. Department d. Employee number e. Total monthly contribution to be paid to Bestmed R Remarks Signature of HR practitioner

Date D D M M

Name stamp of employer