SAPPI APPLICATION FORM FOR REGISTRATION OF DEPENDANTS

bestMed

1. APPLICANT (PRINCIPAL MEMBER)

Title | Date of change (D D M M Y Y Y Y)

First name

Middle name | Initials

Surname

ID number | Gender (M / F) | Preferred language (Eng / Afr)

Home language

Passport number

Membership number | Date of birth (D D M M Y Y Y Y)

Marital status (Unmarried / Married) | Date of marriage/ divorce (D D M M Y Y Y Y)

Current employer

Group division name | Income type (Salary / Wages)

Date of employment (D D M M Y Y Y Y) | Employee number

2. 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 4)* ☐ Child *(if difference in surname, complete declaration in section 5)* ☐ Other

If other, please specify relationship:
(affidavit/legal documents 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 4)* ☐ Child *(if difference in surname, complete declaration in section 5)* ☐ Other

If other, please specify relationship:
(affidavit/legal documents 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 4)* ☐ Child *(if difference in surname, complete declaration in section 5)* ☐ Other

If other, please specify relationship:
(affidavit/legal documents 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 4)* ☐ Child *(if difference in surname, complete declaration in section 5)* ☐ Other

If other, please specify relationship:
(affidavit/legal documents 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 4)* ☐ Child *(if difference in surname, complete declaration in section 5)* ☐ Other

If other, please specify relationship:
(affidavit/legal documents required)

3. ELIGIBILITY OF DEPENDANT(S)

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

Children are regarded as such only up to the age of 21, unless studying (but not older than 26).		
1. Is your child older than 21 and currently studying? Proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant. Please ensure student proof is attached for the current year of study? (Student cards will not be accepted.)	Yes	No
2. Are the adult dependant(s) financially dependent on the principal member?	Yes	No

4. 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 on this day of month Y Y Y Y

Signature of principal member

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

5. 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.
6.

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.

6. THE FOLLOWING DOCUMENTS ARE COMPULSORY

1. 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.
2. In the case of extended family (parent, brother or sister only) - 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: Not a membership card). The aforesaid proof must contain the period and type of cover.
4. In the case of a handicapped child dependant, a report from a medical practitioner.
5. If you are registering a new born baby, a birth certificate/ full ID number/ passport number will be required. It is compulsory that you register your new born baby within 30 days, from date of birth.
6. Ensure that dependant(s) full names and identity numbers are completed. passport numbers required for non-SA citizen.
7. Medical questionnaire:
   - Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, level/stage of illness, condition, nature of treatment, medicine, dosage and hospitalisation).

7. PREVIOUS MEMBERSHIP STATUS

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 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

If "yes", attach the membership certificate(s) of the previous scheme(s), confirming the start and end date of membership.

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

8. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

12.1 Please note: Where the answer is YES, please give full details of the person concerned in the space provided. If 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. ***The examples listed with each section is only a limited list and does not include all possible conditions.***

Have 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/underline*** the diagnosed conditions in relevant tables.	Indicate with an "X" (compulsory)		Name of patient	Date diagnosed	Last treatment date	Please state diagnosis, medicine and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms in the last 12 months
1. Congenital physical deviations: e.g. bat ears, valvular heart disease	Yes	No				
2. Skin conditions/abnormalities (including allergies): e.g. eczema, psoriasis, acne	Yes	No				
3. Skeletal, joint and muscle deviations/problems: e.g. arthritis, back/knee problems, jaw surgery/ problems	Yes	No				
4. Sensory organ problems: hearing, speech, vision (including spectacles and/or contact lenses)	Yes	No				
5. Lung/respiratory problems: e.g. asthma, COPD, bronchitis, bronchiolitis, pulmonary embolism	Yes	No				
6. Heart/Cardio-vascular problems: e.g. hypertension, high cholesterol, heart failure, thrombosis, bypass surgery	Yes	No				
7. Digestive problems: e.g. hiatus hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, liver or pancreas problems	Yes	No				
8. Urinary system problems: e.g. kidney infections/failure/dialysis/stones, bladder problems/ infection, incontinence	Yes	No				
9. Metabolic diseases: e.g. obesity, diabetes type 1 or 2, porphyria, thyroid problems	Yes	No				
10. Mental/psychiatric problems: e.g. depression, anxiety, bipolar mood disorder, sleeping disorders, counselling	Yes	No				
11. Muscular/nervous system: e.g. paralysis, epilepsy, Parkinson's disease, headaches, Stroke, cerebral palsy, paraplegia, hemiplegia, amputations	Yes	No				
12. Substance abuse/dependence: e.g. alcohol, drugs, recent rehabilitation	Yes	No				
13. Cancer diagnosis/treatment, a growth or tumour of any kind? Please state type.	Yes	No				
14. Dental treatment: e.g. fillings, braces, crowns, dentures	Yes	No				
15. Ear, nose and throat problems: e.g. grommets, tonsillitis, sinus/nasal surgery, sinusitis	Yes	No				
16. Any previous operations undergone?	Yes	No				

17. Any other medical condition or ongoing treatment/monitoring that the Scheme should be aware of?	Yes	No				
18. 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				
19. Contagious diseases e.g. positive for HIV/AIDS*, hepatitis B, tuberculosis	Yes	No				

***** If any of your dependants are HIV positive or have AIDS and would prefer not to disclose 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 dependant(s) that are living with HIV/Aids. This information must be disclosed to Bestmed within seven (7) working days from the application date of 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.

20. A condition for which your dependant(s) received a payment and/or medical treatment of whatever nature: e.g. third party claim	Yes	No				
21. Any symptoms experienced in the last 12 months, or other illness or medical condition that you are aware of and not mentioned above, even if your dependant(s) did not consult a doctor?	Yes	No				

22. For males only						
22a. Male reproductive system: e.g. prostate/testes problems, vasectomy, circumcision	Yes	No				
22b. Male hormone system: e.g. hormone replacement therapy	Yes	No				
23. For females only						
23a. Pregnancy or suspected pregnancy. If yes, please confirm gestation	Yes	No				
23b. Female reproductive system: e.g. endometriosis, menstrual problems/irregularities, infertility, hormone replacement therapy, sterilisation/hysterectomy	Yes	No				

12.2 Are your dependant/s currently using any chronic medicine?

Yes | No

If you have answered YES, please complete the separate chronic application form on the website. If registered for chronic medication at the previous medical scheme, please submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription. Important to note: Failure to submit information will result in chronic medicine being paid from acute medicine.

PLEASE NOTE:

- Chronic benefits are granted in accordance with the applicable underwriting.
- Chronic benefits are granted according to the Bestmed formulary per condition per benefit option.
- The formularies are available on the Bestmed website at www.bestmed.co.za
- If non-formulary medicine does qualify for benefits, it will be subject to an additional co-payment.

Important: It remains the responsibility of the applicant to make full disclosure of the required information pertaining to 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 provision 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 on 086 000 2378.

I _____

(principal member name and surname) acknowledge that all information declared above is true and correct.

Signed by me _____ on this ____ day of month Y Y Y Y

Signature of principal member

9. UNDERWRTING THAT MIGHT APPLY

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 principle 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

10. APPLICATION AND DECLARATION

I herewith apply for:
Recognition of my abovementioned dependants as beneficiary(ies) of the Scheme on the grounds that, to the best of my knowledge:
1. The details in respect of your dependant(s) set out above are true and correct and that they qualify for enrolment as dependant(s) in terms of the Scheme Rules;
2. My aforementioned children are fully dependent on me, or, if they have an income, the income does not exceed the maximum basic social pension per year; and
3. My aforementioned dependants are in good health, both mentally and physically. Should an applicant be unable to sign the declaration as required in (1) and (2) on account of temporary absence of a dependant or on account of ill health or of a mental or physical disability of such a dependant, full details should be submitted to the Scheme for consideration.

I undertake on behalf of the above mentioned dependant(s) to abide by the Rules of the Scheme.

Signed by me _____ on this ____ day of month Y Y Y Y

Signature of principal member

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

11. 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.

2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants/child(ren)/spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
   - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.
   - 2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
   - 2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.
   - 2.4 To administer my claims and premiums.
   - 2.5 To activate my medical aid and/or prescribed benefits.
   - 2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.
   - 2.7 For general administration purposes pertaining to my membership.
   - 2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.
   - 2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.
   - 2.10 To provide me with health and wellness information throughout the subsistence of my membership.
   - 2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.
   - 2.12 To analyse my Personal Information collected for research and statistical purposes.
   - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
   - 2.14 To carry out analysis and profiling of my membership profile.

3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

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

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

Yes	No

Signature

12. STATEMENT 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.

Signature of employer

HR practitioner details

Surname

Full names

E-mail

Telephone number

Remarks

Signature of HR practitioner

Date D D M M Y Y Y Y

Name stamp of employer