

MAIN MEMBER AND MINOR DEPENDANT MANAGED HEALTHCARE CONSENT FORM



1. MAIN MEMBER CONSENT

I,

Membership number

hereby give consent to Bestmed Medical Scheme ("Bestmed") to process my Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013, for purposes of managing the following medical condition(s) :

CHRONIC CONDITIONS			
Addison's disease		Crohn's disease	Hypertension
Asthma		Diabetes insipidus	Hypothyroidism
Bipolar mood disorder		Diabetes mellitus type 1	Multiple sclerosis
Bronchiectasis		Diabetes mellitus type 2	Parkinson's disease
Cardiomyopathy		Dysrhythmias	Rheumatoid arthritis
Chronic renal disease		Epilepsy	Schizophrenia
Chronic obstructive pulmonary disease (COPD)		Glaucoma	Systemic lupus erythematosus (SLE)
Cardiac failure		Haemophilia	Ulcerative colitis
Coronary artery disease		Hyperlipidaemia	
NON-CDL CONDITIONS			
Acne - severe		Urinary incontinence	Neuropathy
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)		Gastro-oesophageal reflux disease (GORD)	Polyarteritis nodosa
Allergic rhinitis		Paget's disease	Scleroderma
Eczema		Ankylosing spondylitis	Sjogren's disease
Migraine prophylaxis		Hypopituitarism	Trigeminal neuralgia
Gout prophylaxis		Osteoarthritis	Psoriatic arthritis
Major depression		Alzheimer's disease	Blepharospasm
Obsessive compulsive disorder		Collagen diseases	Dystonia
Osteoporosis		Dermatomyositis	
Psoriasis		Motor neuron disease	
PMBs			
Aplastic anaemia		Female menopause	Paraplegia/Quadriplegia
Chronic anaemia		Fibrosing alveolitis	Polycystic ovarian syndrome
Benign prostatic hypertrophy		Graves' disease	Pulmonary embolism
Cushing's disease		Hyperthyroidism	Stroke
Cystic fibrosis		Hypophyseal adenoma	
Endometriosis		Idiopathic thrombocytopenic purpura	
DISEASE MANAGEMENT			
Back and neck care		Dialysis care	Maternity care
Oncology care		Diabetes care	
HIV/AIDS care		Haematology	
SUPPORT SERVICES			
Alcohol and substance abuse care		Wound care	Stoma care
OTHER (PLEASE SPECIFY)			

1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to my health, medical and treatment records.
2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage my condition(s) as indicated above.
3. I further expressly give informed consent for Bestmed to obtain my Personal/Special Personal Information from any party who may be in possession of information relating to my state of health, treatment received or expected, as well as any other information that may be in possession of that party which Bestmed may deem relevant for the management of my condition(s).
4. I confirm that I am aware of the fact I can revoke my consent for the processing of my Personal/Special Personal Information, at any time by written communication to Bestmed. I also understand that me revoking my consent may result in Bestmed not being able to adequately render medical aid services to me.
5. I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Personal/Special Personal Information.

2. CONSENT ON BEHALF OF MINOR DEPENDANT (CHILD UNDER THE AGE OF 18)

I,

Membership number

in my representative capacity as the Spouse/Partner/Parent/Guardian/Other (Please specify)

of

ID number

hereby give consent to Bestmed Medical Scheme ("Bestmed") to process my Minor Dependand's Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013, for purposes of management of the following medical condition(s) :

CHRONIC CONDITIONS			
Addison's disease		Crohn's disease	Hypertension
Asthma		Diabetes insipidus	Hypothyroidism
Bipolar mood disorder		Diabetes mellitus type 1	Multiple sclerosis
Bronchiectasis		Diabetes mellitus type 2	Parkinson's disease
Cardiomyopathy		Dysrhythmias	Rheumatoid arthritis
Chronic renal disease		Epilepsy	Schizophrenia
Chronic obstructive pulmonary disease (COPD)		Glaucoma	Systemic lupus erythematosus (SLE)
Cardiac failure		Haemophilia	Ulcerative colitis
Coronary artery disease		Hyperlipidaemia	
NON-CDL CONDITIONS			
Acne - severe		Urinary incontinence	Neuropathy
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)		Gastro-oesophageal reflux disease (GORD)	Polyarteritis nodosa
Allergic rhinitis		Paget's disease	Scleroderma
Eczema		Ankylosing spondylitis	Sjogren's disease
Migraine prophylaxis		Hypopituitarism	Trigeminal neuralgia
Gout prophylaxis		Osteoarthritis	Psoriatic arthritis
Major depression		Alzheimer's disease	Blepharospasm
Obsessive compulsive disorder		Collagen diseases	Dystonia
Osteoporosis		Dermatomyositis	
Psoriasis		Motor neuron disease	
PMBs			
Aplastic anaemia		Female menopause	Paraplegia/Quadriplegia
Chronic anaemia		Fibrosing alveolitis	Polycystic ovarian syndrome
Benign prostatic hypertrophy		Graves' disease	Pulmonary embolism
Cushing's disease		Hyperthyroidism	Stroke
Cystic fibrosis		Hypophyseal adenoma	
Endometriosis		Idiopathic thrombocytopenic purpura	

DISEASE MANAGEMENT			
Back and neck care		Dialysis care	Maternity care
Oncology care		Diabetes care	
HIV/AIDS care		Heamatology	
SUPPORT SERVICES			
Alcohol and substance abuse care		Wound care	Stoma care
OTHER (PLEASE SPECIFY)			

1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to the health, medical and treatment records of my Minor Dependant.
2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage the condition(s) of my Minor Dependant, as indicated above.
3. I further expressly give consent for Bestmed to obtain any Personal/Special Personal Information of my Minor Dependant from any party who may be in possession of information relating to my Minor Dependant's state of health, treatment received or expected, as well as any other information that may be in possession of that party that may be deemed relevant by Bestmed for the management of my Minor Dependant's condition(s).
4. I warrant that by giving consent on behalf my Minor Dependant, I do so in my capacity as a competent person in respect of such Personal/Special Personal Information as contemplated in the Protection of Personal Information Act, 4 of 2013.
5. I confirm that I am aware of the fact I can revoke my consent for the processing of the Personal/Special Personal Information of my Minor Dependant, at any time by written communication to Bestmed. I also understand that me revoking this consent may result in Bestmed not being able to adequately render medical aid services to my Minor Dependant.
6. Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Minor Dependant's Personal/Special Personal Information.

Signature

Signed at

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 on this

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 day of

	month				
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