APPLICATION FORM FOR CHRONIC DIALYSIS

1. IMPORTANT INFORMATION

Please complete all sections and return to Bestmed with compulsory pathology reports.
Fax 012 472 6780
Email: mhc@bestmed.co.za

2. PARTICULARS OF PRINCIPAL MEMBER

Surname

Name

Date of birth D D M M Y Y Y Y

Membership number

Tel (W)

Tel (H)

Cell

Fax

E-mail

3. PARTICULARS OF THE APPLICANT

Surname

Name

Date of birth D D M M Y Y Y Y

Cell

E-mail

Dependant code

Patient e-GFR mL/min

4. APPLICANT'S CONSENT

I hereby give permission to the doctor or any other service provider to state the diagnosis and mention any other information relating to my condition(s) on the form. I understand that this information will remain confidential at all times.

Signature of applicant

Date D D M M Y Y Y Y

5. PROVIDER DETAILS

Treating doctor

Practice number

Contact person

Contact details

Doctor's signature

Date D D M M Y Y Y Y

Dialysis company

Practice number

Contact person

Contact details

Doctor's Signature

Date D D M M Y Y Y Y

6. MEDICAL HISTORY

Please note: All questions in this medical history questionnaire must be answered with a yes or no. Where the answer is yes, please give full details of the matter concerned in the space provided.

Have you received any medical treatment, care or medical advice relating to any of the following conditions?	Mark with "X"		Condition		Level/stage of illness, condition, nature of treatment, medication dosage and hospitalisation.
			Date	Period	
Psychopathology e.g. Schizophrenia	Yes	No			
Cerebrovascular disease, Peripheral vascular disease	Yes	No			
Substance abuse	Yes	No			
Metastatic malignancy	Yes	No			
Viable transplant candidate	Yes	No			
HIV Positive	Yes	No			
Chronic lung disease	Yes	No			
Diabetes	Yes	No			
Other Diseases	Yes	No			
Please specify other:					

Signature of applicant

Date D D M M Y Y Y Y

7. INITIATION QUESTIONNAIRE

Please complete if e-GFR > 6mL/min and < 15mL/min	Mark with "X"		Comment
Symptoms or signs of uraemia	Yes	No	
Diuretic resistant fluid overload	Yes	No	
Poorly controlled blood pressure	Yes	No	
Evidence of malnutrition	Yes	No	

8. CLINICAL QUESTIONNAIRE

Reason for kidney failure				
Current medicine				
ICD-10 code(s)		Previous acute dialysis	Yes	No
Start date		End date		

9. TYPE OF DIALYSIS

Type of Dialysis	Mark with "X"	
Chronic Haemodialysis	75148	
Continuous Ambulatory Peritoneal Dialysis	75176	

10. COMMENTS

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 of applicant