

**1. APPLICANT (PRINCIPAL MEMBER)**

Title

Surname

Full names

Date of birth of principal member         Language preference  Eng  Afr

Marital status  Unmarried  Married  Date of marriage

ID number  Gender  M  F

**2. BENEFIT OPTION**

Non-Network benefit options (Indicate with 'X')			
Beat1	<input type="checkbox"/>	Pace1	<input type="checkbox"/>
Beat2	<input type="checkbox"/>	Pace2	<input type="checkbox"/>
Beat3	<input type="checkbox"/>	Pace3 *	<input type="checkbox"/>
Beat4	<input type="checkbox"/>	Pace4	<input type="checkbox"/>

Network benefit options (Indicate with 'X')	
Beat1N (Network) †	<input type="checkbox"/>
Beat2N (Network) †	<input type="checkbox"/>
Beat3N (Network) †	<input type="checkbox"/>
Beat4N (Network) †	<input type="checkbox"/>

\* Basic salary per annum  R

†	Initial
<b>Take note: If any of the BeatN options is 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:</b>	
1. I am limited to a hospital network as determined by the Scheme.	<input type="checkbox"/>
2. I am aware of the location of the nearest above-mentioned network hospital providers.	<input type="checkbox"/>
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 (as set out in the brochure).	<input type="checkbox"/>
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.	<input type="checkbox"/>

‡	Initial
<b>Take note: If any of the Pulse options is 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:</b>	
1. Primary care service provider network	<input type="checkbox"/>
2. Specialist network	<input type="checkbox"/>
3. Hospital network	<input type="checkbox"/>

Initial of applicant:



## 6. PREVIOUS MEMBERSHIP STATUS

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 termination certificate

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

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

Late joiner penalties can be imposed on new members over the age of 35. Depending on the number of years the member did not belong to a medical scheme, a late joiner penalty will be added to the member's monthly 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 member 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 contribution
5 - 14 years	0.25 x contribution
15 - 24 years	0.50 x contribution
25+ years	0.75 x contribution

## 7. BANKING DETAILS FOR CLAIMS REIMBURSEMENT

Account holder:

Surname

Full names

ID number

Bank

Branch name

Branch code

Account number

Account

Cheque

Savings

Date

Signature of applicant

Signature of account holder (if different from applicant)

**Note: Please attach a copy of your bank statement (not older than 3 months). Details cannot be loaded without this required information.**

## 8. MEDICAL QUESTIONNAIRE

**Please note:** All questions in the medical history questionnaire must be answered with a YES or NO. 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.

Have you or any of your proposed beneficiary(-ies) received any medical advice, diagnosis, care or was treatment recommended or received for the following within the 12-month period ending on the date on which you are applying for membership?	Indicate with an "X"		Name of patient	Date diagnosed	Level/stage of illness, condition, nature of treatment, medication, 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	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, cholesterol	Yes	No			
7. Digestive system e.g. hiatus hernia, stomach ulcer	Yes	No			
8. Bladder, kidney and sexual system	Yes	No			
9. Nervous system e.g. paralysis, epilepsy, parkinsonism	Yes	No			
10. Hormone system e.g. hormone replacement therapy	Yes	No			
11. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems	Yes	No			
12. Psychiatric or psychological treatment e.g. depression, anxiety	Yes	No			
13. Substance dependence e.g. alcohol, drugs	Yes	No			

14. Pregnant or suspected pregnancy	Yes	No			
15. Have you ever been diagnosed with cancer? Please state type and date.	Yes	No			
16. Operations undergone. Please state type and date.	Yes	No			
17. Are you and/or your dependant(s) currently being treated for a medical condition or symptoms not stipulated above?	Yes	No			
18. A condition for which you and/or your dependant(s) received a payment and/or medical treatment of whatever nature e.g. third party claim	Yes	No			
19. Any other medical condition not mentioned above, even though you or your dependant(s) did not receive treatment or advice or consult a doctor in the past 12 months?	Yes	No			
20. Current medication used	Yes	No			
21. Dental treatment	Yes	No			
22. Contagious diseases e.g. positive for HIV/AIDS, Hepatitis B, Tuberculosis	Yes	No			
23. If you and/or any of your dependants are HIV positive or have AIDS and would prefer not to disclose your and/or their HIV status on this form due to confidentiality, then you must call 012 472 6249 or send an e-mail to mhcbestmed.co.za in order to notify Bestmed of your and/or your dependant(s) that you and/or your dependants are living with HIV/Aids. This information must be disclosed to Bestmed within seven (7) working days from the application date of your and/or 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.	Yes	No			

**Please note: if you are currently using chronic medication, also complete the separate application form available on the website, or call 086 000 2378**

## 9. HEALTHCARE ADVISOR DECLARATION

- 1) I declare that I am an accredited Bestmed healthcare advisor, I am fully licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Healthcare Advisor Services Act 37 of 2002 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.

## 10. SUMMARY OF MONTHLY COST

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																			
<b>MONTHLY TOTAL (1-3)</b>	R																			

Healthcare advisor name \_\_\_\_\_

Healthcare advisor code 

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Healthcare advisor signature \_\_\_\_\_ Date 

D	D	M	M	Y	Y	Y	Y
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## 11. STATEMENT OF APPLICANT

I, \_\_\_\_\_ hereby declare that:

- a. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;
- b. I understand that if my application for membership is approved and accepted, the information furnished on my application form will be used as the basis of my application and the payment of benefits in the future;
- c. I irrevocably hereby grant permission on behalf of myself as well as on behalf of my dependant(s) (if applicable) to any physician, person or party who may be in possession of or obtain information concerning my state of health or that of my dependant(s), treatment received or expected as well as any other relevant information to divulge such information to Bestmed or its proxy on demand, also after my death or that of my dependant(s); I understand that this information together with other information will be used to evaluate the payment of benefits for certain medical conditions, I warrant that I have obtained my dependant(s) consent to grant this authorisation;
- d. I undertake to pay my share of accounts to Bestmed; on default, I hereby authorise my employer/business to deduct the amount due from my salary or should I resign, I hereby authorise my employer/business to deduct the amount due from my pension or any other monies due to me and pay this over to Bestmed;
- e. If after my admission as a member of Bestmed it is found that any statement or information furnished by me was knowingly and/or wilfully inadequate, incomplete or untrue, I agree to refund in full to Bestmed all payments which Bestmed may have made on my behalf and to relinquish any claim to any benefits on the part of Bestmed;
- f. Any deterioration or change in my state of health or in that of any dependant(s) before the date or event to be set by Bestmed for commencement of membership, or the date of acceptance of this application by Bestmed, or the date of receipt of the first subscription, whichever date is the latest shall entitle Bestmed to reconsider the application and propose new terms of admission or declare the membership null and void in which case all monies paid to Bestmed in connection with this membership before Bestmed is informed of the change, shall be forfeited and benefits paid by Bestmed shall immediately be refunded to Bestmed;
- g. Bestmed reserves the right to cancel membership should it become apparent that false information was wilfully supplied on this application.

Signature of applicant \_\_\_\_\_

Signature of witness \_\_\_\_\_

## 12. STATEMENT BY ESKOM

To be completed by Employer **(ALL FIELDS COMPULSORY)**

### HR practitioner details:

Surname

Full names

E-mail

Telephone number

State that the applicant

a. Has been **permanently** employed by us since

b. Deduction start date with Bestmed

c. Personnel Area Description

Personnel Area Code

d. Personnel Sub-Area

Personnel Sub-Area Code

e. Personnel number

f. Total monthly contribution to be paid to Bestmed

Description	Number of dependants	Number subsidised
Spouse/life partner		
Child		
Adult (other)		

Remarks/Kommentaar \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of HR practitioner/Handtekening van MH-praktisyn

Date

Shared Services HR Stamp