

1. APPLICANT (PRINCIPAL MEMBER) / AANSOEKER (HOOFID)

Title
Titel

Surname
Van

Full names
Volle name

Date of birth of principal member
Geboortedatum van hooflid Language preference
Taalvoorkeur Eng Afr

Marital status
Huweliksstatus Unmarried Married Date of marriage
Datum van huwelik

ID number
ID-nommer Gender
Geslag M F

Current employer
Huidige werkgewer

Period employed
Tydperk in diens

2. BENEFIT OPTION / VOORDEELOPSIE

Benefit option (Indicate with 'X') / Voordeelopsie (Dui aan met 'X')

Beat1	<input type="checkbox"/>	Beat1N (Network) †	<input type="checkbox"/>	Pace1	<input type="checkbox"/>	Pulse1 * ‡	<input type="checkbox"/>
Beat2	<input type="checkbox"/>	Beat2N (Network) †	<input type="checkbox"/>	Pace2	<input type="checkbox"/>	Pulse2 ‡	<input type="checkbox"/>
Beat3	<input type="checkbox"/>	Beat3N (Network) †	<input type="checkbox"/>	Pace3 *	<input type="checkbox"/>		
Beat4	<input type="checkbox"/>			Pace4	<input type="checkbox"/>		

* Provide **proof of income** (3 months' payslips or bank statements - not older than 3 months) for the Pace3 and Pulse1 options.
* Voorsien **bewys van inkomste** (3 maande se betaalstrokiens of bankstate - nie ouer as 3 maande nie) vir die Pace3 en Pulse1 opsies.

†	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: Let wel: Indien enige van die BeatN opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die doeltreffendheidsafslag wat op die BeatN opsies van toepassing is, neem ek kennis en stem toe tot die volgende:	Initial Parafeer
	1. I am limited to a hospital network as determined by the Scheme. 1. Ek is beperk tot 'n hospitaalnetwerk soos deur die Skema bepaal.	
	2. I am aware of the location of the nearest above-mentioned network hospital providers. 2. Ek is bewus van die naaste bovermelde hospitaal netwerkverskaffers se ligging.	
	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). 3. As ek uit vrye keuse nie van die voormelde netwerkverskaffer gebruik maak nie, is ek bewus daarvan en stem ek toe dat ek verantwoordelik gehou sal word vir 'n bybetaling in gevolg van die Skemareëls (soos in die brosjure bepaal).	
	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. 4. Ek is bewus dat hierdie 'n unieke voordeelopsie is en dat ek nie gedurende die jaar van 'n BeatN-opsie na 'n standaard Beat-opsie, in gevolg van die Skemareëls, mag skuif nie.	

‡	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: Let wel: Indien enige Pulse opsies gekies word, parafeer asseblief langs die onderstaande. Vanweë die gekontrakteerde aangewese diensverskaffersnetwerk wat betrekking het tot die Pulse opsies, neem ek kennis en stem toe dat my gekose unieke voordeelopsie onderhewig is aan die volgende:	Initial Parafeer
	1. Primary care service provider network 1. Primêresorg diensverskaffersnetwerk	
	2. Specialist network 2. Spesialisnetwerk	
	3. Hospital network 3. Hospitaalnetwerk	

Date of inception
Aanvangsdatum

6. PREVIOUS MEMBERSHIP STATUS / VORIGE LIDMAATSKAPSTATUS

Have you and/or your spouse/partner and/or dependant(s) been a member(s) or dependant(s) of a medical scheme(s)?
Was u en/of u gade/metgesel en/of afhanklike(s) 'n lid/afhanklike van 'n mediese skema(s)?

Yes/Ja

No/Nee

If "yes" attach termination certificate
Indien "ja" heg beëindigingsertifikaat aan

Name of scheme Naam van skema	Member number Lidmaatskapnommer	Principal member Hooflid	Dependant Afhanklike	Date from Datum vanaf	Date to Datum tot

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.

Laataansluitingsboete (in gevolge Regulasie 131 van die Wet op Mediese Skemas (Wet 131 van 1998))

Laataansluitingsboetes kan op nuwe lede wat ouer as 35 jaar is gehef word. Afhangende van die aantal jare waartydens die lid nie aan 'n mediese skema behoort het nie, sal 'n laataansluitingsboete by die maandelikse bydrae gevoeg word. Die boete word bereken op 'n glyskaal soos uiteengesit in die onderstaande tabel en word gebaseer op die totale aantal jare ná die ouderdom van 35 effektief 1 April 2001, waartydens die lid nie aan 'n mediese skema behoort het nie.

Number of years since age 35 where applicant was not a member of a medical scheme Aantal jare sedert ouderdom 35 waartydens die aansoeker nie 'n lid van 'n mediese skema was nie	Penalty Boete
1 - 4 years / jaar	0.05 x contribution / bydrae
5 - 14 years / jaar	0.25 x contribution / bydrae
15 - 24 years / jaar	0.50 x contribution / bydrae
25+ years / jaar	0.75 x contribution / bydrae

7. BANKING DETAILS FOR CLAIMS REIMBURSEMENT / BANKBESONDERHEDE VIR EISBETALINGS

Account holder:
Rekeninghouer:

Surname
Van

Full names
Volle name

ID number
ID-nommer

Bank

Branch name
Taknaam Branch code
Takkode

Account number
Rekeningnommer

Account
Rekening Cheque / Tjek Savings / Spaar

Date
Datum

Signature of applicant
Handtekening van aansoeker

Signature of account holder (if different from applicant)
Handtekening van rekeninghouer (indien verskillend van aansoeker)

**Note: Please attach a copy of your bank statement (not older than 3 months). Details cannot be loaded without this required information.
Nota: Heg asseblief 'n afskrif van u bankstaat aan (nie ouer as 3 maande nie). Besonderhede kan nie opgelaa word sonder hierdie vereiste inligting nie.**

8. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

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.

Let wel: Alle vrae in die mediese geskiedenis-vraelys moet met 'n JA of NEE beantwoord word. In die geval van 'n JA, moet die volle besonderhede van die betrokke persoon voorsien word in die beskikbare spasie. Indien u of enige van u afhanklikes aan 'n chroniese siektoestand lei, word 'n mediese verslag benodig wat die besonderhede uiteensit. Indien die spasie voorsien nie voldoende is nie, verskaf asseblief besonderhede op 'n afsonderlike bladsy en heg dit by hierdie vraelys aan.

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? Het u of u voorgestelde begunstigde(s) in die laaste 12 maande voor hierdie aansoek om lidmaatskap enige mediese behandeling of sorg of advies rakende enige van die volgende toestande ontvang?	Indicate with an "X"		Name of patient Naam van pasiënt	Date diagnosed Datum gediagnoseer	Level/stage of illness, condition, nature of treatment, medication, dosage and hospitalisation Graad/stadium van toestand, aard van behandeling, medikasie, dosis en hospitalisasie
	Yes /Ja	No / Nee			
1. Congenital physical deviations e.g. bat-ears, valvular heart disease Kongenitale fisiese afwykings bv. bakore, hartklepsiektes	Yes /Ja	No / Nee			
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis Velabnormaliteit (insluitende allergieë) bv. ekseem, psoriase	Yes /Ja	No / Nee			
3. Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems Skelet-, gewrigs- en spierafwykings en probleme bv. arthritis, rugprobleme	Yes /Ja	No / Nee			
4. Sensory organs: sight, hearing, speech, also state spectacles and/or contact lenses Sintuie: sig, gehoor, spraak, meld brille en/of kontaklense	Yes /Ja	No / Nee			
5. Respiratory system e.g. asthma, COPD Siektes van die lugweë bv. asma, KOLS	Yes /Ja	No / Nee			
6. Cardio-vascular systems e.g. hypertension, cholesterol Siektes van die kardiovaskulêre stelsel bv. hipertensie, cholesterol	Yes /Ja	No / Nee			
7. Digestive system e.g. hiatus hernia, stomach ulcer Spysverteringstelselsiektes bv. hiatus hernia, maagseer	Yes /Ja	No / Nee			
8. Bladder, kidney and sexual system Blaas-, nier- en geslagstelselsiektes	Yes /Ja	No / Nee			
9. Nervous system e.g. paralysis, epilepsy, parkinsonism Senuweestelselsiektes bv. verlamming, epilepsie, parkinsonisme	Yes /Ja	No / Nee			
10. Hormone system e.g. hormone replacement therapy Hormoonstelsel bv. hormoonvervangingsterapie	Yes /Ja	No / Nee			
11. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems Metaboliese siektes bv. vetsug, diabetes, porfirie, skildklierprobleme	Yes /Ja	No / Nee			
12. Psychiatric or psychological treatment e.g. depression, anxiety Psigiatriese of sielkundige behandeling bv. depressie, angs	Yes /Ja	No / Nee			
13. Substance dependence e.g. alcohol, drugs Middelafhanklikheid bv. alkohol, dwelms	Yes /Ja	No / Nee			

14. Pregnant or suspected pregnancy Swanger of vermoede van swangerskap	Yes / Ja	No / Nee		
15. Have you ever been diagnosed with cancer? Please state type and date. Is kanker ooit voorheen by u gediagnoseer? Spesifiseer tipe en datum.	Yes / Ja	No / Nee		
16. Operations undergone. Please state type and date. Operasies ondergaan. Spesifiseer tipe en datum.	Yes / Ja	No / Nee		
17. Are you and/or your dependant(s) currently being treated for a medical condition or symptoms not stipulated above? Word u en/of u afhanklike(s) tans vir 'n mediese toestand of simptome behandel?	Yes / Ja	No / Nee		
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 'n Toestand waarvoor u en/of u afhanklike(s) 'n uitbetaling en/of gewaarborgde mediese behandeling van welke aard ook ontvang het, bv. derdeparty eis	Yes / Ja	No / Nee		
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? Enige ander mediese aangeleentheid wat nie hierbo gemeld is nie, selfs al het u of u afhanklike(s) nie behandeling of advies ontvang of 'n dokter gekonsulteer in die laaste 12 maande nie?	Yes / Ja	No / Nee		
20. Current medication used Huidige medisyne	Yes / Ja	No / Nee		
21. Dental treatment Tandheilkundige behandeling	Yes / Ja	No / Nee		
22. Contagious diseases e.g. positive for HIV/AIDS, Hepatitis B, Tuberculosis Oordraagbare / aansteeklike siektes bv. positief vir MIV/VIGS, Hepatitis B, Tuberkulose 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. Indien u en/of enige van u afhanklikes MIV-positief is of VIGS het en verkies om nie u en/of hul MIV-status op hierdie vorm wil meld nie, weens vertroulikheid, moet u 012 472 6249 skakel of 'n e-pos stuur na mhcbestmed.co.za om Bestmed in kennis te stel van u en/of u afhanklike(s) dat u en/of u afhanklikes met MIV/Vigs saamleef. Hierdie inligting moet binne sewe (7) werksdae vanaf die datum van u aansoek vir u en/of u afhanklike(s) se lidmaatskap aan Bestmed gemeld word. By ontvangs van die versoek sal Bestmed bepaal of onderskrywingstoestande toegepas sal word, en indien dit die geval is, sal 'n dokument met 'n gewysigde bewys van lidmaatskap ontvang.	Yes / Ja Yes / Ja	No / Nee No / Nee		

**Please note: if you are currently using chronic medication, also complete the separate application form available on the website, or call 086 000 2378
Let wel: indien u tans chroniese medisyne gebruik, voltooi ook die afsonderlike aansoekvorm wat beskikbaar is op die webwerf, of skakel 086 000 2378**

9. STATEMENT OF APPLICANT / VERKLARING DEUR AANSOEKER

I, _____
_____ hereby declare that:

- a. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;
- b. The information furnished herein is completely true and correct to the best of my knowledge and conviction and that I have not omitted or concealed any information; I unconditionally accept membership for 12 months and understand that a savings account will be allocated pro rata (if applicable);
- c. 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;
- d. 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;
- e. 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;
- f. 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;
- g. 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;
- h. Bestmed reserves the right to cancel membership should it become apparent that false information was wilfully supplied on this application.
- i. I acknowledge that my date of application does not necessarily refer to my date of admission as a member of Bestmed. I further acknowledge that my date of admission will be communicated to me by Bestmed as soon as possible hereafter.

Ek, _____
_____ verklaar dat:

- a. Indien ek as lid van Bestmed ingeskryf word, ek my aan die reëls van Bestmed onderwerp;
- b. Die inligting hierbo na die beste van my wete en oortuiging volkome waar is en dat ek geen inligting verswyg het nie. Ek aanvaar onvoorwaardelik lidmaatskap vir 12 maande en dat die mediese spaarrekening pro rata bereken word (waar van toepassing);
- c. Ek verstaan dat indien my aansoek om lidmaatskap goedgekeur en aanvaar word, die inligting vervat in my aansoekvorm in die toekoms die basis sal vorm van my aansoek en die betaling van voordele;
- d. Ek gee onherroeplik toestemming aan enige geneesheer, persoon of instansie wat in besit mag wees of in besit mag kom van inligting aangaande my gesondheid of dié van my afhanklike(s), om die inligting aan Bestmed of sy gevolmagtigde te openbaar, ook na my dood of dié van my afhanklike(s). Ek verstaan dat die inligting tesame met ander inligting in ag geneem sal word met die evaluasie van betalings ten opsigte van sekere mediese toestande. Ek waarborg dat ek my afhanklike(s) se toestemming verkry het om hierdie magtiging te verleen;
- e. Ek onderneem om my bydrae op rekeninge aan Bestmed te vereffen en by versuim magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my salaris af te trek, of indien ek sou bedank, magtig ek my werkgewer/onderneming hiermee om die verskuldigde bedrag van my pensioen of enige ander gelde aan my betaalbaar af te trek en aan Bestmed oor te betaal;
- f. Indien daar na my toelating as lid van Bestmed gevind word dat enige verklaring of inligting deur my verstrekk, willens en/of wetens onvoldoende of onwaar was, ek toestem om alle betalings wat Bestmed namens my gemaak het, ten volle terug te betaal en om alle aanspreeklikheid op enige voordele aan die kant van Bestmed, te verbeur;
- g. Enige verswakking of verandering in my gesondheidstoestand of in dié van my afhanklikes voor die datum of gebeurtenis wat deur Bestmed vir die aanvang van lidmaatskap gestel sal word, of die datum van die aanvaarding van hierdie aansoek deur Bestmed, of die datum van ontvangs van die eerste ledegelde, watter een ookal laaste is, Bestmed die reg sal gee om die aansoek te heroorweeg en nuwe voorwaardes vir toelating voor te stel of die lidmaatskap nietig te verklaar, in welke geval alle gelde wat ten opsigte van hierdie lidmaatskap aan Bestmed betaal is voordat Bestmed kennis van die verandering ontvang het, verbeur word en uitbetaalde voordele onverwyld aan Bestmed terugbetaal sal word;
- h. Bestmed behou die reg om lidmaatskap onverwyld te kanselleer indien dit aan die lig sou kom dat valse inligting willens en wetens met hierdie aansoek verskaf is.
- i. Ek is bewus daarvan dat die datum van my aansoek nie noodwendig verwys na die datum van my toelating as 'n Bestmed-lidmaat nie en dat die toelatingsdatum so spoedig moontlik deur Bestmed aan my gekommunikeer sal word.

Signature of applicant/Handtekening van aansoeker

Signature of witness/Handtekening van getuie

DEBIT ORDER-BESTMED CONTRIBUTIONS DEBIETORDER-BESTMED BYDRAE

1. APPLICANT (PRINCIPAL MEMBER) / AANSOEKER (HOOFID)

Title
Titel

Surname
Van

ID number
ID-nommer

2. MONTHLY DEBIT ORDER / MAANDELIKSE DEBIETORDER

Name of option
Naam van opsie _____

TOTAL MONTHLY SUBSCRIPTION
TOTALE MAANDELIKSE SUBSKRIPSIE

R

3. DETAILS OF BANK ACCOUNT / BESONDERHEDE VAN BANKREKENING

Account holder
Rekeninghouer

Bank

Branch name
Taknaam Branch code
Takkode

Account number
Rekeningnommer

Type of account
Rekeningsoort Cheque / Tjek Savings / Spaar

* Day of debit order
* Dag van debietorder 20th/20^{ste} 25th/25^{ste} 1st/1^{ste}

* Or the first working day thereafter * Of die eerste werksdag daarna

I/we hereby authorise Bestmed to draw against my/our account with the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account) the sum of R _____ on the above mentioned date or the first working day thereafter. I/we further authorise Bestmed to adjust the amount due as fees are amended from time to time. All such withdrawals from my/our account by Bestmed shall be treated as though they have been signed by me/us personally. I/we agree to pay bank charges relating to this debit order instruction. This authority may be cancelled by me/us by giving Bestmed one month's notice in writing via e-mail, fax or registered post, starting on the first day of the following calendar month, provided that this may not be done within 12 calendar months without the written permission of Bestmed. Should there be a breach of this contract there is a possibility that the member will be held responsible for payments incurred. I/we understand that I/we shall not be entitled to any refunds of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Bestmed. I/we acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/ authority to any third party without prior written consent of the authorised party.

Subscription fees are payable in advance and therefore deduction of debit order will take place in the month before inception date should you choose the 20th or 25th as the debit order date.

Ek/ons magtig hiermee Bestmed om geld te onttrek uit my/ons rekening by die bogenoemde bank (of enige bank of tak waarna ek/ons my/ons rekening oorplaas) ten bydrae van R _____ op die bogemelde datum of die eerste werksdag daarna. Ek/ons bemagtig Bestmed verder om die bedrag aan te pas soos wat die ledegelde van tyd tot tyd verander. Alle sodanige onttrekkings van my/ons rekening sal geag word asof deur my/ons persoonlike geteken. Ek/ons onderneem om bankkoste gekoppel aan hierdie debietorder te betaal. Ek/ons mag hierdie magtiging kanselleer deur Bestmed een maand skriftelik via e-pos, faks of geregistreerde pos in kennis te stel, vanaf die eerste dag van die opvolgende kalendermaand, op voorwaarde dat dit nie gedoen mag word binne 12 kalendermaande sonder skriftelike toestemming van Bestmed nie. Indien daar kontrakbreuk sou wees, bestaan die moontlikheid dat die lid aanspreeklik gehou sal word vir kostes aangegaan. Indien bydrae wettiglik verskuldig was aan Bestmed, verstaan ek/ons dat ek/ons nie geregtig sal wees op enige terug betaling van bydrae wat onttrek is terwyl hierdie magtiging van krag was nie. Ek/ons bevestig dat die onttrekking teen my/ons rekening nie deur die gemagtigde party gesedeer mag word en dat die gemagtigde party nie enige van sy regte mag oordra na 'n derde party sonder my/ons vooraf skriftelike toestemming nie en dat ek/ons nie enige verpligtinge ingevolge hierdie kontrak/magtiging aan enige derde party delegeer sonder vooraf skriftelike toestemming van die derde party nie.

Ledegeld is vooruit betaalbaar en word in die maand voor registrasie gevorder indien die 20^{ste} of 25^{ste} gekies word as die debietorder datum.

Signature of principal member/Handtekening van hooflid _____

Signature of account holder/ Handtekening van rekeninghouer _____

Signed at
Geteken te _____ on the
op die _____ day of
dag van _____ 20 ____