

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

Title  
Titel

Surname  
Van

Full names  
Volle name

Date of birth of principal member  
Geboortedatum van hoofid  D  D  M  M  Y  Y  Y  Y Language preference  
Taalvoorkeur  Eng  Afr

Marital status  
Huwelikstatus  Unmarried  Married  Date of marriage  
Datum van huwelik  D  D  M  M  Y  Y  Y  Y

ID number  
ID-nommer  Gender  
Geslag  M  F

**2. BENEFIT OPTION / VOORDEELOPSIE**

Benefit option (Indicate with 'X') / Voordeelopsie (Dui aan met 'X')					
Beat3	Beat3N (Network) †	Pace1		Pulse2 ‡	
Beat4	Beat4N (Network) †	Pace2			
		Pace3 *			
		Pace4			

\* Basic salary per annum/Jaarlikse basiese salaris  R

†	Initial Parafeer
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:	
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 gevolge 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 gevolge van die Skemareëls, mag skuif nie.	

‡	Initial Parafeer
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:	
1. Primary care service provider network 1. Primêresorg diensverskaffersnetwerk	
2. Specialist network 2. Spesialisnetwerk	
3. Hospital network 3. Hospitaalnetwerk	

Initial of applicant:  
Paraaf van aansoeker:



## 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			

	Yes / Ja	No / Nee		
14. Pregnant or suspected pregnancy Swanger of vermoede van swangerskap				
15. Have you ever been diagnosed with cancer? Please state type and date. Is kanker ooit voorheen by u gediagnoseer? Spesifiseer tipe en datum.				
16. Operations undergone. Please state type and date. Operasies ondergaan. Spesifiseer tipe en datum.				
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?				
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				
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?				
20. Current medication used Huidige medisyne				
21. Dental treatment Tandheelkundige behandeling				
22. Contagious diseases e.g. positive for HIV/AIDS, Hepatitis B, Tuberculosis Oordraagbare / aansteeklike siektes bv. positief vir MIV/VIGS, Hepatitis B, Tuberkulose				
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. 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.				

**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. 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.

Ek, \_\_\_\_\_  
\_\_\_\_\_ verklaar dat:

- a. Indien ek as lid van Bestmed ingeskryf word, ek my aan die reëls van Bestmed onderwerp;
- b. 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;
- c. 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;
- d. 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;
- e. 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;
- f. 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;
- g. 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.

\_\_\_\_\_  
Signature of applicant/Handtekening van aansoeker

\_\_\_\_\_  
Signature of witness/Handtekening van getuie



## 12. STATEMENT BY EMPLOYER / VERKLARING DEUR WERKGEWER

To be completed by Employer **(ALL FIELDS COMPULSORY)** / Moet deur Werkgewer voltooi word **(ALLE VELDE VERPLIGTEND)**

Employer name  
Naam van Werkgewer

Employer code  
Werkgewerkode

### HR practitioner details:

#### Menslikehulpbronne-praktisyn besonderhede:

Surname  
Van

Full names  
Volle name

E-mail  
E-pos

Telephone number  
Telefoonnommer

State that the applicant/Verklaar dat die aansoeker:

a. Has been **permanently** employed by us since/Is **permanent** in ons diens is vanaf

b. Bestmed membership to start/Bestmed lidmaatskap aanvangsdatum

c. Department/Departement

d. Personnel number/Personeelnommer

e. Total monthly contribution to be paid to Bestmed  
Totale maandelikse ledegeld betaalbaar aan Bestmed

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Remarks/Kommentaar

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Signature of HR practitioner/Handtekening van MH-praktisyn

Date  
Datum

Name stamp of employer/Naamstempel van werkgewer