Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: AONN01A1IBBF

CORPORATE APPLICATION FORM
KORPORATIEWE AANSOEKVORM

bestMed

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

Title
Titel

Surname
Van

Full names
Volle name

Date of birth of principal member
Geboortedatum van hooflid: 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')

Beat1		Beat1N (Network) †		Pace1		Pulse1 * ‡	
Beat2		Beat2N (Network) †		Pace2		Pulse2 ‡	
Beat3		Beat3N (Network) †		Pace3 *			
Beat4				Pace4			

* Basic salary per annum/Jaarlikse basiese salaris: R

† 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 netwerkverskaffers 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.	

‡ 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	

Initial of applicant:
Paraaf van aansoeker:

3. DEPENDANTS / AFHANKLIKES

Name Naam	Surname (if different from principal member) Van (indien verskil van hooflid)	Gender Geslag	ID number (date of birth for non-SA citizens: DDMMYYYY) ID-nommer (geboortedatum vir nie-SA burgers: DDMM J J J J)	Relationship* Verwantskap*
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		

* The rules of the Scheme will determine admission and the applicable rates.

* Die Skemareëls sal die toelating en die toepaslike tariewe bepaal.

4. THE FOLLOWING DOCUMENTS ARE COMPULSORY / DIE VOLGENDE DOKUMENTE IS 'N VEREISTE

If a child is older than 21, proof of registration at a tertiary institution (up to the age of 26) is required in order to qualify as a child dependant or a statement if the child is older than 21 and unemployed.		As 'n kind ouer as 21 is, word 'n bewys van registrasie by 'n tersiêre instelling (tot op 'n ouderdom van 26) verlang om as 'n kinderafhanklike te kwalifiseer, of 'n verklaring indien die kind ouer as 21 en werkloos is.
In the case of extended family (parent, brother or sister only) - affidavit of dependant(s) with regards to dependency on principal member.		In die geval van uitgebreide familie (slegs ouer, broer of suster) - beëdigde verklaring van afhanklike(s) met betrekking tot afhanklikheid van hooflid.
Proof of previous medical scheme membership must be provided; this applies to members and all dependants (NB: Not a membership card). The aforesaid proof must contain the period and type of cover.		Bewys van lidmaatskap van vorige mediese skemas; dit geld vir lede sowel as alle afhanklikes (LW: Nie 'n lidmaatskapkaart nie). Die bogenoemde bewys moet die soort en tydperk van dekking insluit.
In the case of a handicapped child dependant, a report from a medical practitioner.		In die geval van 'n gestremde kinderafhanklike, 'n verslag van 'n mediese praktisyn.
In the case of registering a life partner as a dependant, a declaration with regards to shared household responsibility.		In die geval waar 'n lewensmaat geregistreer word as afhanklike, 'n verklaring met betrekking tot gemeenskaplike huishoudelike verantwoordelikheid.

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER) / ADRES EN KONTAKBESONDERHEDE (HOOFLID)

Residential address
Woonadres

Code
Kode

(Domicilium citandi et executandi)

Postal address
(If different from residential)
Posadres
(Indien anders as woonadres)

Code
Kode

Please take note that all future hard-copy correspondence will be sent to the postal address provided above.
Let wel dat alle toekomstige hardekopie korrespondensie gestuur sal word na die posadres soos bo verskaf.

Tel (W)

Tel (H)

Cell numbers:
Selfoonnommers:

Fax
Faks

Principal member
Hooflid

Dependant
Afhanklike

Name
Naam

Dependant
Afhanklike

Name
Naam

Dependant
Afhanklike

Name
Naam

E-mail
E-pos

Total member cards required
Aantal lidmaatskapkaarte benodig

Until receiving your membership card/s via post, you are able to download your e-card via the Bestmed App.
Tot tyd en wyl u lidmaatskap kaart/e u bereik, kan u gerus u e-kaart aflaai via die Bestmed App.

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

It is important to note that proof of previous membership may prevent possible waiting periods being imposed.
Let daarop dat bewys van vorige lidmaatskap moontlike wagperiodes wat toegepas mag word, kan voorkom.

7. BANKING DETAILS FOR CLAIMS REIMBURSEMENT / BANKBESONDERHEDE VIR EISBETALINGS

Account holder:
Rekeninghouer:

Surname
Van

Full names
Volle name

ID number
ID-nommer

Bank
Bank

Branch name
Taknaam

Branch code
Takkode

Please circle the relevant blocks and print **YOUR ACCOUNT NUMBER** in the **last row**
Omsirkel asseblief die betrokke blokkies en skryf u **REKENINGNOMMER** in die **laaste ry**

0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

Type of account
Rekening tipe

Cheque / Tjek

Savings / Spaar

Signature of applicant
Handtekening van aansoeker

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

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8. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

Please note: 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: 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 siektetoestand lei, word 'n mediese verslag benodig wat die besonderhede uiteensit. Indien die spasie wat voorsien word 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" (compulsory) Dui aan met 'n "X" (verpligtend)		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
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. artritis, 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. Urinary system, e.g. kidney problems (infections, failure, dialysis, stones) or bladder problems (infection, incontinence) Urienwegsisteem, bv. nierprobleme (infeksies, versaking, dialise en stene) of blaasprobleme (infeksie, inkontinensie)	Yes / Ja	No / Nee			
9. Male reproductive system, e.g. prostate and testes problems Manlike reproduktiewe sisteem, bv. prostaat- en testesprobleme	Yes / Ja	No / Nee			
10. Female reproductive system, e.g. endometriosis, menstrual problems and infertility Vroulike reproduktiewe sisteem, bv. endometriose, menstruele probleme en onvrugbaarheid	Yes / Ja	No / Nee			
11. Hormone system e.g. hormone replacement therapy Hormoonstelsel bv. hormoonvervangingsterapie	Yes / Ja	No / Nee			
12. Pregnant or suspected pregnancy Swanger of vermoede van swangerskap	Yes / Ja	No / Nee			
13. Nervous system e.g. paralysis, epilepsy, Parkinson's disease Senuweestelselsiektes bv. verlamming, epilepsie, Parkinsonse siekte	Yes / Ja	No / Nee			
14. Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems Metaboliese siektes bv. vetsug, diabetes, porfirie, skildklierprobleme	Yes / Ja	No / Nee			

Initial of applicant:
Paraaf van aansoeker:

15. Psychiatric or psychological treatment e.g. depression, anxiety Psigiatriese of sielkundige behandeling bv. depressie, angs	Yes / Ja	No / Nee			
16. Substance dependence e.g. alcohol, drugs Middelafhanklikheid bv. alkohol, dwelms	Yes / Ja	No / Nee			
17. 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			
18. Operations undergone. Please state type and date. Operasies ondergaan. Spesifiseer tipe en datum.	Yes / Ja	No / Nee			
19. 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 wat nie bo vermeld word nie?	Yes / Ja	No / Nee			
20. 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 ookal ontvang het, bv. derdeparty eis	Yes / Ja	No / Nee			
21. Current medication used Huidige medisyne wat gebruik word	Yes / Ja	No / Nee			
22. Dental treatment Tandheelkundige behandeling	Yes / Ja	No / Nee			
23. 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 mhc@bestmed.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 te meld nie, weens vertroulikheid, moet u 012 472 6249 skakel of 'n e-pos stuur na mhc@bestmed.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 u 'n dokument met 'n gewysigde bewys van lidmaatskap ontvang.	Yes / Ja	No / Nee			
24. 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			

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

Initial of applicant:
Paraaf van aansoeker:

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 accept 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. 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 the appointed broker (if applicable) up to a maximum amount as set by the Medical Schemes Act.

i. Bestmed reserves the right to cancel membership should it become apparent that false information was wilfully supplied on this application.

j. I hereby consent to my personal health information being processed by Bestmed for the purpose of determining my medical risk profile and to my information being further processed by any managed healthcare partner, loyalty benefits partners or any separate entities that provide health-related services independently, or on behalf of Bestmed, for inter alia the purpose of:

- selecting beneficial wellness programme options on behalf of the members;
- allowing agents of such managed healthcare partners, loyalty benefits administrators or independent entities to determine the optimal products and services to be offered to Bestmed members;
- offering said options, products and services to members with their prior consent.

I hereby affirm that I am aware that the processing of my personal health information is a mandatory requirement for the existence of a valid medical insurance agreement between the parties and that I am aware of my right to object to the processing and/or further processing of my personal information and of my right to lodge a complaint to the information regulator.

Ek, _____

_____ verklaar dat:

a. Indien ek as lid van Bestmed ingeskryf word, ek my aan die reëls van Bestmed sal onderwerp;

b. Die inligting hierin na die beste van my wete en oortuiging volkome waar is en dat ek geen inligting verswyg het nie. Ek aanvaar 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 verstrek, 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 verklaar dat ingevolge Wet 131 van 1998 van die Wet op Mediese Skemas (of soos gewysig), 'n maandelikse statutêre kommissie aan die vasgestelde makelaar uitbetaal sal word, tot en met die maksimum bedrag soos vasgestel deur die Wet op Mediese Skemas.

j. Ek gee hiermee toestemming dat my persoonlike gesondheidsinligting deur Bestmed verwerk mag word met die doel om my mediese risikoprofiel te bepaal en dat my inligting verder verwerk mag word deur enige bestuurdesorgvennoot, loyaliteitsprogramvennoot of enige afsonderlike entiteit wat gesondheidsverwante dienste onafhanklik aanbied, of namens Bestmed inter alia vir die doel om:

- voordelige gesondheidsorgprogramme namens die lede te verkies;
- sodat agente van sodanige gesondheidsorgprogramme, administrateurs van lojaliteitsvoordele of onafhanklike entiteite die optimale dienste en produkte mag bepaal wat aangebied gaan word aan Bestmed-lede;
- dat die bogemelde opsies, produkte en dienste aangebied mag word aan die lede wat hul toestemming vooraf daarvoor gegee het.

Ek bevestig hiermee dat ek daarvan bewus is dat die verwerking van my persoonlike gesondheidsinligting 'n verpligte vereiste vir die bestaan van 'n geldige mediese versekeringsooreenkoms tussen die partye is, en dat ek bewus is van my reg om teen die verwerking en/of verdere verwerking van my persoonlike inligting beswaar te mag maak, en op my reg om 'n formele klag te mag lê by die inligtingsreguleerder.

Signature of applicant/Handtekening van aansoeker

Signature of witness/Handtekening van getuie

10. 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 D D M M Y Y Y Y

b. Bestmed membership to start/Bestmed lidmaatskap aanvangsdatum D D M M Y Y Y Y

c. Department/Departement

d. Personnel number/Personeelnommer

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

Remarks/Kommentaar

Signature of HR practitioner/Handtekening van MH-praktisyn

Date
Datum D D M M Y Y Y Y

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: AONN01A1IBBF

Name stamp of employer/Naamstempel van werkgewer

Aon
Empower Results®

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon South Africa (Pty) Ltd to be my duly appointed Broker with immediate effect.

My ID ☐☐☐☐☐☐☐☐☐☐☐☐☐ and membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

I have also been informed of the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum of R75.00 excl. Vat per month. I have further been issued with a Statutory Notice and Section 13 certificate.

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ____________________

Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical Scheme ____________________ Aon Broker Code ____________________

Title ☐☐☐☐ Initials ☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name(s) (as per identity document) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

To clarify this, the following information will be made available:

Personal examples	**Benefit examples**	**Financial examples**	**Medical examples**
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon South Africa (Pty) Ltd to provide me with any products that they consider appropriate to me.

Yes ☐ No ☐

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ____________________