Broker House: Aon South Africa (Pty) Ltd

Tel No: 0860 100 404

Broker Code: AONN01A1IBBF

INDIVIDUAL APPLICATION FORM



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- that your option is subject to the following:

 - 2. Specialist network (Referral required from network GP)
 - 3. Hospital network
- Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, RSA PO Box 2297, Pretoria, 0001, RSA Client Service 086 000 2378 Fax +27 (0)12 472 6500 E-mail membership@bestmed.co.za www.bestmed.co.za Reg no. 1252

Broker House: Aon South Africa (Pty) Ltd

3. HEALTHCARE ADVISOR DECLARATION

Tel No: 0860 100 404

Broker Code: AONN01A1IBBF

1. I declare that I am an accredited Bestmed healthcare advisor, I am a registered advisor in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 to sell Healt
Service Benefits, 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.
- 9. I am aware of the submission cut-off date for new registrations.

4. SUMMARY OF MONTHLY COST

Failure to complete the below section in full will result in unsuccessful broker commission payments

TOTAL MONTHLY PREMIUM								R					
Healthcare advisor name													
Healthcare advisor code													
Broker House: Aon Sout	h Afr	ica (Pty)	Ltd									

Date

M

M

Tel No: 0860 100 404

Broker Code: AONN01A1IBBF

Healthcare advisor signature

5. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address																		
Telephone number (w)										Fax	c numb	er						
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Is your physical addres	s the s	ame as	your p	ostal a	ddress?	?	Yes	١	Vo									
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Please download the Bestmed App for access to your digital membership card on date of registration, and look out for an SMS with a link after registration has been completed.

6. YOUR BANKING DETAILS

For monthly con									ınking d	letails l	pelow													
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Entity registratio	n numb	er																						
OTHER																								
Title																								
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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 contribution amount for the selected benefit option on the above mentioned date or the first working day thereafter. I/we further authorise Bestmed to adjust the amount due

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^{*} The Scheme Rules will determine admission and the applicable rates.

10. UNDERWRITING POLICY

It is important to note that proof of previous membership may prevent possible waiting periods being imposed:

The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a Dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application:

- A general waiting period of up to 3 (three) months;
- A condition-specific waiting period of up to 12 (twelve) months.

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:

- A condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;
- In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme

The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application.

A general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

Bestmed will implement waiting periods and evaluate and/or investigate information and membership in all cases where adverse selection is exercised to obtain specific benefits.

Monitor for possible non-disclosure

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

- a) Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
- b) When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application.

In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation.

In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

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

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

11. PREVIOUS MEMBERSHIP STATUS

Please supply ALL previous membership certificates, from a South African registered medical scheme for you and your dependants, as relevant proof of previous medical aid cover. The submission of previous medical aid certificates will ensure correct and relevant underwriting is applied on your new profile. In the event that you are unable to obtain previous membership certificate(s), Bestmed will accept an affidavit if previous cover exceeds 5 years. Visit www.bestmed.co.za to complete affidavit in the relevant blocks. Please refer to applicant checklist (section 14) of this form for more details.

 $Have you\ and/or\ your\ spouse/partner\ and/or\ dependant (s)\ been\ a\ member\ or\ dependant\ of\ a\ medical\ scheme?$

Yes No

I was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months with no break in membership between previous medical scheme and Bestmed, contributions at my previous scheme were paid in arrears therefore I would like to continue to pay Bestmed in arrears.

According to the Medical Scheme's Act a member/dependant may not belong to 2 medical schemes at the same time therefore it is imperative that we receive a certificate with a resign date to continue with the registration process.

If "yes" please attach all previous membership certificates

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

12. MEDICAL QUESTIONNAIRE

12.1 This section is extremely important:

Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders, irrespective of it being chronic or acute and no matter how insignificant it may seem. If the answer is YES, please give full details of the person and condition concerned in the space provided. If the space provided is insufficient, provide the details on a separate page and attach it to this questionnaire, medical reports may be included. The examples listed under each condition below are not intended as a full list of conditions, disorders or symptoms, but only serve as examples. In other words, the examples below are only a limited list and do not include all possible conditions. Please note that all fields are compulsory.

Have you or any of your dependants been given medical advice or a diagnosis or medical care before the date on which you are applying for membership, irrespective of it being chronic or acute and no matter how insignificant it may seem? Please clearly specify the diagnosed conditions in relevant tables.		te with "X" ulsory)	Name of patient	Specify illness/condition/ disorder in full	Date of first diagnosis or problem	Latest consultation/ test/treatments with dates	Please state ALL medicines: name and dosage, nature of treatment, level/stages of illness, hospitalisation, treatment/care/advice/symptoms, dates of last symptoms experienced
Infectious diseases e.g. hepatitis B, tuberculosis, tetanus, bilharzia, etc.	Yes	No					
	163	NO					
2. Positive for HIV/AIDS*	.,						
	Yes	No					
* If you and/or any of your dependants are HIV positive or have AIDS and would prefer Bestmed of your and/or your dependant(s) that you and/or your dependants are living receipt of this request Bestmed will determine whether underwriting conditions will be	with HIV	/AIDS. Th	is information must be disclosed to I	Bestmed within seven (7) v	working days from t		
 Cancer diagnosis/treatment, or a growth or tumour of any kind? Please state type - benign or malignant. 							
Spe Seng. S. Hallgrand	Yes	No					
4. Blood conditions: e.g. anaemia, blood clotting problems, deep vein thrombosis, pulmonary embolism, platelet deficiencies, haemophilia, leukaemia, lymphoma, bleeding disorders.	Yes	No					
5. Endocrine and metabolic conditions : e.g. obesity, diabetes mellitus, porphyria,							
thyroid problems, Cushing syndrome, metabolic syndrome, Addison disease, any other endocrine or metabolic conditions	Yes	No					
 Psychiatric conditions: e.g. depression, anxiety, bipolar disorder, autism, Asperger syndrome, sleeping disorders (e.g. narcolepsy), insomnia, eating disorders, drug 							
or alcohol use disorder or rehabilitation, suicide attempt, post-traumatic stress disorder, counselling, recent psychological trauma.	Yes	No					
 Brain and nervous system or neuromuscular conditions: e.g. paralysis, epilepsy, Parkinson disease, headaches, stroke, cerebral palsy, paraplegia, hemiplegia, carpal tunnel syndrome, chronic headache, migraine, multiple sclerosis, motor 	Yes	No					
neuron disease, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability.	163	NO					
8. Eye and eyelid conditions: e.g. vision problems, blurry vision, glasses, cataracts, keratoconus, corneal ulcers, glaucoma, squint, ptosis, retinal detachment,							
retinopathy, macular degeneration, retinal vein occlusion, corneal transplant, eye surgery, partial or full blindness, astigmatism, any other eye or eyelid condition.	Yes	No					
Ear, nose and throat problems: e.g. grommets, otitis media, tinnitus, ear infections, deafness, hearing problems, use of hearing aids, cochlear implant,		_					
tonsillitis or adenoiditis, dizziness, vertigo, previous sinus or nasal surgery, sinusitis, deviated nasal septum, allergic rhinitis, chronic blocked nose or sinuses.	Yes	No					

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10. Heart and circulation problems: e.g. high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins.	Yes	No	
Lung and breathing problems: e.g. asthma, COPD/emphysema, bronchitis, bronchiolitis, pulmonary embolism, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia.	Yes	No	
12. Digestive and gastrointestinal problems: e.g. hiatus/abdominal/inguinal hernia, reflux/heartburn, stomach ulcer, spastic colon, constipation, gallstones, hepatitis, cirrhosis, portal hypertension, alcohol or fatty liver disease, liver failure, pancreatitis, cystic fibrosis, Crohn disease, ulcerative colitis, diverticulitis, jaundice.	Yes	No	
13. Skin condition (including allergies): e.g. eczema, psoriasis, acne, chronic wounds, melanoma, skin cancer, sunspots, warts, skin tags, mole irritation or shape and colour change.	Yes	No	
14. Dental, oral, and maxillofacial consultation and/or treatment: e.g. dental fillings, orthodontics, crowns, dentures, implants, temporomandibular joint disorders, jaw surgery, cleft lip or palate, etc.	Yes	No	
15. Skeletal, joint and muscle deviations/problems: e.g. neck/back/knee/hip problems/pain, arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus (SLE), gout, clubfoot, bunions, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, etc	Yes	No	
16. Kidney and urinary conditions: e.g. kidney failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, etc.	Yes	No	
17. Male reproductive system: e.g. prostate cancer, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, vasectomy, circumcision, erectile dysfunction, etc.	Yes	No	
18. Pregnancy or suspected pregnancy? If yes, please confirm gestation/duration of pregnancy. Are you currently undergoing treatment towards getting pregnant? Provide date of Last Normal Menstruation (LNM).	Yes	No	
19. Female reproductive system: e.g. endometriosis, menstrual problems or irregularities, infertility, hormone replacement therapy, sterilisation/ hysterectomy, abnormal Pap smear result, polycystic ovarian syndrome, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, etc.	Yes	No	
20. Congenital deviations: e.g. bat ears, cleft palate, patent ductus arteriosus (PDA), heart defects, Down Syndrome, neural tube defects, spina bifida, brain defects, ventricular septum defect (VSD), etc.	Yes	No	
21. Rare disorders/conditions: e.g. congenital disorders of glycosylation, Hunter syndrome, lysosomal storage diseases, Klinefelter syndrome, etc.	Yes	No	

Any symptoms experienced, or other illness/medical condition that you are aware of not mentioned above, even if no doctor was consulted and irrespective							
of treated with lifestyle changes or self-medication?	Yes	No					
 Current medication used, not yet stated above, even if not on a chronic basis. If yes, please attach a list if this space is not sufficient. 							
	Yes	No					
24. Any previous operations undergone?							
	Yes						
 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. 	V	Ne					
	Yes	No					
Any other medical condition or ongoing treatment/monitoring that is not mentioned on the application form that may result in a claim within the next							
12 months?	Yes	No					
	1		1				
Please note that the complete medical questionnaire does not serve as arm medication at the previous medical scheme, submit a copy of the previous	n applic	ation fo	or chronic benefits, kindly down	load and complete se	parate chronic a	pplication form	from our website; if registered for chronic
meancation at the previous meancar seneme, submit a copy of the previous	5 2111 011	- uutii	on sales in letter together with a	copy or the most rece	prescription,	.pp. 00u. 15 5ubje	ter to protocolor

Important: It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all the dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. Any misstatement in, or omission from this form whether wilful or in ignorance may lead to refusal to admit any claims, suspension or termination of membership. Should a new medical condition arise between the time of completing this application form and the commencement date of membership, the Scheme must be informed immediately. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact Bestmed's Contact Centre on 086 000 2378

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(pri	incip	al mei	mber n	ame ai	nd surr	name) a	acknow	ledge t	hat all	inform	ation d	leclare	d above	is true	e and co	orrect.							
Signed by me	!										on th	iis			day o	of		month	1	Υ	Υ	Υ	Υ
	_	Signati	ure of p	orincipa	al mem	nber						_											

13. 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.
- 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

14. APPLICANT CHECKLIST

Please ensure the following	compulsory	, documents/	information	are compl	eted and	attached.

- 1. If the child is older than 24 years, a declaration statement is required. Adult rates will be applicable.
- 2. In the case of extended family (parent, brother or sister, grandchild) affidavit of dependant(s) with regards to dependency on principal member.
- 3. Proof of previous medical scheme membership must be provided; this applies to members and all dependants (NB: Previous membership card/s not accepted). The aforesaid proof must contain the period of cover.
- 4. Upon completing an affidavit, ensure full details are disclosed e.g. applicable dependants, day, month, year, names of previous schemes.
- 5. If disabled, please complete a report by your medical practitioner or ITRDD SARS form.
- 6. If you selected a Bestmed Rhythm option, provide proof of income for both the main member and spouse (3 months) payslips or bank statements not older than 3 months).
- 7. Ensure that dependant(s) full names and identity numbers are completed. Passport numbers and Country of Issue required for non-SA citizen.
- 8. Medical questionnaire:
 - Each question must be completed in full (Yes/No indicator, beneficiary, diagnosed date, last treatment date, dates of last symptoms experienced, diagnosed condition, medicine and dosage, nature of treatment, level/stages of illness and hospitalisation).
- 9. Chronic application:
 - If registered for chronic medication at the previous medical scheme, submit a copy of the previous chronic authorisation letter together with a copy of the most recent prescription, approval is subject to protocols.

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(principal member name and surname) hereby declare that:

- a. Should I be enrolled as a member of Bestmed, I shall subject myself to the rules of Bestmed;
- b. By signing this form, I agree to the terms and conditions of Bestmed's Beat network options and Rhythm options where applicable.
- c. 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);
- d. 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;
- e. 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;
- f. 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;
- g. 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.
- h. Any deterioration or change in my state of health or in that of my 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.
- i. If after or during 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, Bestmed reserves the right to cancel the membership. If such is the case, 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;

By signing this form, I agree to the terms and conditions of Bestmed's membership registration and confirm that I have fully read and understood each of the pages included in this form.

Signature of app	licant												
								ı					
Signed at						on this		day of	month	Υ	Υ	Υ	Υ

Cut-off date for submission of new applications is the 27th of the month, this is to secure the following months start date. Incomplete applications or missing documents may impede the start date.



Benefits of appointing Aon South Africa Healthcare

as your intermediary

Across Aon, we are united in our passion to provide you with the insights and support to make Better Decisions around all aspects of your holistic wellbeing, medical scheme, gap cover and primary care insurance. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:



our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- Microsites: Provides you with access to voice recorded Induction, Yearend launch highlight presentations, brochures, COVID-19 updates, various application forms.
- Aon Resolution Centre: Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- Year-end renewal communications: Access to the following:
 - Alert Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
 - Member letter Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
 - Guidance letter Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.

Client Assistance Programme

- We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding inperson or video sessions). The following services are available through our third- party service provider, LifeAssist:
 - Structured Telephonic Counselling
 - Telephonic Trauma Support
 - Financial Wellbeing Coaching
 - Legal Advisory Services
 - Health and Wellness Services (professional advice from a dietician and a biokineticist)

General Updates:

Ad-hoc updates pertaining to Medical schemes industry and providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is no additional fee charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products, we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

For more information, contact Aon South Africa:

0860 100 404 | arc@aon.co.za | www.aon.co.za

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to www.aon.co.za

http://www.facebook.com/Aonhealthcare Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica Click "follow" on our profile

Aon Employee Benefits Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

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Privacy Notice

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Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.



Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za

FSP number: 20555; CMS number: ORG895

Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

l acknowledge a scheme membe		South Africa (Pty) Ltd as my financial advisor for all matters related to my medical
My ID:		and membership number:
Signed at (Town	or City):	on yy/mm/dd:
services. Aon ear medical scheme. commission is 3%	ns monthly comn Monthly commis 6 of the monthly	no additional fee charged by Aon for providing you with healthcare intermediary hission which is already included in the monthly contribution you pay over to the sion is part of your total monthly contributions paid to the scheme. This monthly contribution to a maximum amount payable (as disclosed on the Brokers ms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax
-		nal information as well as personal information of all dependents included on my I consent to Aon South Africa (Pty) Ltd accessing information listed on the table
I give consent fo	r the disclosure	of information about me.
Membership nu	mber:	ID or passport number:
Title:	Initials:	Surname:
First name(s) (as	s per identity do	cument):

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit



By signing this letter of appointment, I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City):	on yy/mm/dd:
Signature:	