CORPORATE APPLICATION FORM
KORPORATIEWE AANSOEKVORM

bestMed
Better living. Better life.

FOR OFFICE USE ONLY / SLEGS VIR KANTOOR GEBRUIK

Membership number Lidmaatskapnommer	Organisation number Organisasie nommer	Date of admission Datum van toelating	Contribution Ledegeld

Healthcare advisor code
Kode van Gesondheidsorg-adviseur

Applicant to complete sections 1-9. HR practitioner to complete section 10. Complete in block letters.
Afdelings 1-9 moet deur die aansoeker voltooi word. Werkgewer moet afdeling 10 voltooi. Voltooi in blokletters.

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

Title
Titel _____

Surname
Van _____

Full names
Volle name _____

Date of birth of member
Geboortedatum van lid D D M M Y Y Y Y

Language preference
Taalvoorkeur Eng Afr

Marital status
Huwelikstatus _____

Date of marriage/divorce
Datum van huwelik/egskeiding D D M M Y Y Y Y

ID number
ID nommer

Gender
Geslag Eng Afr

(Need copy of ID/Passport / Benodig afskrif van ID/Paspoort)

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

Residential address
Residensiële adres _____

Postal code
Poskode _____

Medical correspondence to be sent to
Stuur mediese korrespondensie na _____

Postal code
Poskode _____

Fax
Faks _____

E-mail
E-pos _____

Tel (w) _____

Tel (h) _____

Cell
Sel _____

Deliver starter pack via courier at (Physical address)
Lewer beginpak af via koerier by (Fisiese adres) _____

Total member cards
Aantal lidkaarte

3. DEPENDANTS / AFHANKLIKES

Name Naam	Surname (If different from principal member) Van (Indien verskillend van hooflid)	Gender Geslag	ID number ID nommer	Relationship* Verwantskap*
		M F		Spouse Partner Child Other
		M F		Gade Metgesel Kind Ander
		M F		Spouse Partner Child Other
		M F		Gade Metgesel Kind Ander
		M F		Spouse Partner Child Other
		M F		Gade Metgesel Kind Ander
* Declare other/Verklaar ander				

"Other" is defined as a parent, brother or sister of a member for whom the member is de facto liable for family care and support, and for whom contributions as for adult dependants are payable, if older than 21 years. / "Ander" word omskryf as 'n ouer, broer of suster van 'n lid vir die de facto aanspreeklik is vir gesinsorg en onderhoud, en vir wie ledegeld vir volwasse afhanklikes betaalbaar is, indien ouer as 21 jaar. Children are regarded as such only up to the age of 21, unless studying (but not older than 26) or dependent on the member due to a mental or physical disability. Tot op die ouderdom van 21, word kinders as minderjarig geag, tensy die kind studeer (nie ouer as 26 nie) of as gevolg van fisiese of verstandelike gestremdheid, afhanklik is van die hooflid.

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

- A copy of the ID or passport of the principal member and/or dependant(s)
- If a child is older than 21 - proof of full time registration at a tertiary institution (up to the age of 26)
- Extended family - declaration of dependant(s)
- Certificate(s) of previous membership at another medical scheme
- Please note that all applicants must provide proof of previous medical scheme membership (this applies to members or all dependants)
- Please provide proof of address such as a utility bill
- Please provide proof of bank account (Statement or letter from bank must not be older than 3 months.)

- 'n Kopie van die ID of paspoort van die hooflid en/of afhanklike(s)
- As 'n kind ouer as 21 is - bewys van voltydse registrasie by 'n tersiêre instelling (tot op 'n ouderdom van 26)
- Addisionele familie - verklaring van afhanklike(s)
- Sertifikaat(e) van vorige lidmaatskap by 'n ander mediese skema
- Neem asseblief kennis daarvan dat alle aansoekers bewys van lidmaatskap van vorige mediese skemas moet voorsien (Dit geld vir lede sowel as alle afhanklikes)
- Verskaf asseblief bewys van resedensiëlle adress soos 'n munisipaleteits rekening
- Verskaf asseblief bewys van bankbesonderhede (Bankstaat of 'n brief van die bank nie ouer as 3 maande nie.)

5. 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
As "ja" heg terminasie sertifikaat aan

Scheme details Skemabesonderhede		Status		Period Periode	
Name of scheme Naam van skema	Member number Lidnommer	Member Lid	Dependant Afhanklike	From Vanaf	To Tot

Late Joiner Penalty

Late joiner penalties can be imposed on new members over the age of 35. Depending on the number of years where 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

Laataansluitingsboetes kan gehef word op nuwe lede wat ouer as 35 jaar is. 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

HEALTHCARE ADVISOR DECLARATION / GESONDHEIDSORG-ADVISEUR SE VERKLARING

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

2) I accept that the applicant has appointed me as his/her Healthcare Advisor and that he/she is entitled to cancel 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 commission of 3% from the total premium up to a maximum of R65.65 will be paid out to me.

5) I acknowledge that there has been no physical 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) The applicant is familiar with the information required in the application form and he/she has provided all the correct information.

7) The advice and support given to the applicant was unbiased and in his/her best interest.

8) The applicant has personally signed this application form.

1) Ek verklaar dat ek 'n geakkrediteerde Bestmed Gesondheidsorg-adviseur is, ek is ten volle gelisensiëer deur die Raad op Finansiële Dienste (RFD) in terme van die Finansiële Advies-en Gesondheidsorgadviesdienste-wet, Wet 37 van 2002.

2) Ek aanvaar dat die aansoeker my aangestel het as sy/haar Gesondheidsorg-adviseur en dat hy/sy geregtig is om my dienste te kanselleer.

3) Ek bevestig dat die aansoeker my persoonlike besonderhede, insluitend my fisiese en posadres sowel as my telefoonnommer ontvang het.

4) Ek erken dat in terme van Wet 131 van 1998 van die Wet op Mediese Skemas (of soos gewysig), 'n maandelikse kommissie van 3% van die totale premie tot 'n maksimum van R65.65 aan my uitbetaal sal word.

5) Ek erken dat daar geen fisiese wanvoorstelling van enige feite deur my is nie en dat in die geval van materiële of onwettige optrede, ek verantwoordelik sal wees vir die terugbetaling van alle gelde wat betaal is in die effek van so 'n wanvoorstelling.

6) Die aansoeker is bekend met die inligting wat benodig word in die aansoekvorm en hy/sy het al die korrekte inligting verskaf.

7) Die raad en ondersteuning wat gegee was aan die aansoeker is onbevooroordeeld en in sy/haar beste belang.

8) Die aansoeker het persoonlik hierdie aansoekvorm onderteken.

Healthcare Advisor name
Naam van Gesondheidsorg-adviseur MSP CONSULTANTS

Healthcare Advisor code
Gesondheidsorg-adviseurkode MSPN01A1CBLM
MSPF01A1CBLM

Healthcare Advisor signature/Handtekening van Gesondheidsorg-adviseur

Datum
Date D D M M Y Y Y Y

6. MEDICAL HISTORY OF APPLICANT / MEDIESE GESKIEDENIS VAN AANSOEKER

Name of Naam van	Length Lengte (in cm)	Weight Gewig (in kg)
Principal Applicant Hoof Aansoeker		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		

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 as well as the estimated annual cost of treatment thereof. If the space provided is insufficient, write the details on a separate page and attach it to this questionnaire.

Neem kennis: 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 relevante 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 asook die benaderde jaarlikse bedrag vir behandeling daarvan. Indien die ruimte voorsien nie voldoende is nie, verskaf asseblief besonderhede op 'n aparte bladsy en heg dit by hierdie vraelys aan.

7. MEDICAL QUESTIONNAIRE / MEDIESE VRAELYS

Have you or your dependant(s) received any medical treatment or care in the past 12 months or medical advice relating to any of the following conditions? Het u of u afhanklike(s) in die laaste 12 maande enige mediese behandeling of sorg of advies rakende enige van die volgende toestande ontvang?	Indicate with an "X" in the appropriate column Toon aan met 'n "X" in die toepaslike kolom		Name of patient Naam van pasiënt	Condition Toestand		Level/stage of illness, condition, nature of treatment, medication dosage and hospitalisation Graad/stadium van toestand, aard van behandeling, medikasie, dosis en hospitalisasie
				Date Datum	Period Periode	
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. Sense organs: sight, hearing, speech, also state spectacles and/or contact lenses as well as visual strength reading if available Sintuie: sig, gehoor, spraak, meld brille en/of kontaklense asook oogsterktelesings indien beskikbaar	Yes / Ja	No / Nee				
5. Respiratory system e.g. asthma Siektes van die lugweë bv. asma	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 dependance e.g. alcohol, drugs Substansafhanklikheid bv. alkohol, dwelms	Yes / Ja	No / Nee				
14. Dental treatment Tandheelkundige behandeling	Yes / Ja	No / Nee				
15. A condition for which you and/or your dependant(s) receive 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 bv. derdepartyeis	Yes / Ja	No / Nee				
16. Pregnant or suspected pregnancy Swanger of vermoede van swangerskap	Yes / Ja	No / Nee				

17. Previous abnormal pregnancies Vorige abnormale swangerskappe	Yes / Ja	No / Nee				
18. Contagious diseases e.g. HIV, Hepatitis B, Tuberculosis Oordraagbare / aansteeklike siektes bv. MIV, Hepatitis B, Tuberkulose	Yes / Ja	No / Nee				
19. Operations undergone Operasies ondergaan	Yes / Ja	No / Nee				
20. Are you and/or your dependant(s) currently being treated for a medical condition? Word u en/of u afhanklike(s) tans vir 'n mediese toestand behandel?	Yes / Ja	No / Nee				
21. Present medicine Huidige medisyne	Yes / Ja	No / Nee				
22. 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				
23. Do you and/or your dependant(s) participate in professional or dangerous amateur sport, like power-driven vehicle sport, glider sport, scuba diving, bungee or parachute jumping? If so, provide details: Neem u of u afhanklikes deel aan beroepsport- of gevaarlike amateursportsoorte soos kragaangedrewe voertuigsport, sweeftuigsport, skubaduik / duiklongsport, rekspring en valskermspring? Indien wel, verstrek besonderhede:	Yes / Ja	No / Nee	Nature of the sport / Aard van sportsoort	Person(s) participating / Persoon wat deelneem		Injuries / Beserings

Signature of member/Handtekening van lid

Date / Datum: D D M M Y Y Y Y

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MSP CONSULTANTS
P.O BOX 1434. FOURWAYS. 2055
TEL: 011 462 8361 / 1256
011 704 1946
FAX: 086 723 0104

8. 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 should my application for membership be 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 sickness conditions, I guarantee 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/undertaking to deduct the amount due from my salary or should I resign, I hereby authorise my employer/ undertaking 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 wilfully inadequate 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 moneys 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 application.

Ek, _____

_____ verklaar dat:

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

b. Die inligting hierin verstrek is 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 mediesespaarrekening pro rata bereken word (waar van toepassing);

c. Ek verstaan dat sou 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 onherroeplik toestemming gee 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 toestande. Ek bevestig dat ek my afhanklike(s) se toestemming verkry het om hierdie magtiging te verleen;

e. Ek onderneem om my bydrae op rekenings aan Bestmed te vereffen en by versuim ek my werkgewer/onderneming hiermee magtig 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 of wetens onvoldoende of onwaar was, ek toestem om alle betalings wat Bestmed in my belang mag 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 onverwyd aan Bestmed terugbetaal sal word;

h. Bestmed behou die reg om lidmaatskap te kanselleer behou indien dit aan die lig sou kom dat valse inligting willens en wetens met aansoek verskaf is.

_____

Signature of applicant/Handtekening van aansoeker

_____

Signature of witness/Handtekening van getuie

9. CLAIM REIMBURSEMENT DETAILS / EIS BETALINGS BESONDERHEDE

Account holder
Rekeninghouer _____

Bank _____

Branch name and town
Taknaam en dorp _____

Account number
Rekeningnommer | | | | | | | | | | | | | | | | | Branch number
Takkode | | | | | | |

Type of account
Tipe rekening Cheque / Tjek Savings / Spaar

Title
Titel _____ Surname
Van _____

Full names
Volle name _____

ID number
ID nommer | | | | | | | | | | | | | |

Date
Datum D D M M Y Y Y Y

_____ _____

Signature of applicant
Handtekening van aansoeker

Signature of witness
Handtekening van getuie

Note: Please attach a copy of bank statement (not older than 3 months). Details cannot be loaded without the relevant information.
Nota: Heg asseblief 'n afskrif van u bankstaat aan (nie ouer as 3 maande nie). Besonderhede kan nie opgelaai word sonder relevante inligting nie.

10. STATEMENT BY EMPLOYER TO APPLICANT / VERKLARING DEUR WERKGEWER AANGAANDE AANSOEKER

To be completed by Employer / Moet deur Werkgewer voltooi word

Employer name
Naam van Werkgewer _____ Employer code
Werkgewerkode _____

Name of HR practitioner
Naam van Menslikehulpbronne-praktisyn _____ Contact number
Telefoon nommer _____

State that the applicant/Verklaar dat die aansoeker:

a. Has been permanently employed by us since/In ons diens is vanaf D D M M Y Y Y Y *Compulsory field Verpligte veld

b. Start date/Aanvangs datum D D M M Y Y Y Y *Compulsory field Verpligte veld

c. Salary per annum/Jaarlikse salaris R _____ *Compulsory field Verpligte veld

d. Department / Departement _____ Administrative / Administratief Academic / Akademies

e. Personnel number / Personeelnommer _____

f. Total monthly contribution to be paid to Bestmed/Totale maandelikse ledegeld betaalbaar aan Bestmed (R _____)

g. Option choice (See overleaf)

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Benefit option Voordeelopsie	
Beat1♥	
Beat2♥	
Beat3♥	
Beat4♥	

Benefit option Voordeelopsie	
Pace1♥	
Pace2♥	
Pace3♥	
Pace4♥	

Benefit option Voordeelopsie	
Pulse1♥	
Pulse2♥	

IMPORTANT/BELANGRIK

I would like to receive Bestmed marketing material/Ek wil graag Bestmed bemarkingsmateriaal ontvang | Yes/Ja | No/Nee

I would like to receive Top Living, Bestmed's electronic magazine/Ek wil graag Top Living, Bestmed se elektroniese tydskrif ontvang. | Yes/Ja | No/Nee

Signature of member/Handtekening van lid

Date
Datum | D | D | M | M | Y | Y | Y | Y |

Signature of HR/Handtekening van MH - Praktisyn

Name stamp of employer/Naam stempel van werkgewer

Remarks/Kommentaar:

Human Resources practitioner/Menslike Hulpbron-praktisyn

Telephone number/Telefoonnommer