

INDIVIDUAL MEMBER BENEFIT OPTION CHANGE FORM



1. APPLICANT (PRINCIPAL MEMBER)

Membership number

Surname

Initials ID number

2. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Telephone number (w) Cellphone number

Physical address

Code

3. BENEFIT OPTION

Benefit option (indicate with 'X')

| | | | | | | | |
|------------|--|--------------------|--|-------|--|-------------|--|
| Beat1 | | Beat1N (Network) † | | Pace1 | | Rhythm1 * ‡ | |
| Beat2 | | Beat2N (Network) † | | Pace2 | | Rhythm2 * ‡ | |
| Beat3 | | Beat3N (Network) † | | Pace3 | | | |
| Beat3 Plus | | | | Pace4 | | | |
| Beat4 | | | | | | | |

Income bracket if you are joining on the Rhythm1 Option

| | | |
|--------------------------|-------------------------------|----------------------------------|
| R 0 - R 9 000 monthly | R 9 001 - R 14 000 monthly | R 14 001 and above monthly |
|--------------------------|-------------------------------|----------------------------------|

Income bracket if you are joining on the Rhythm2 Option

| | | |
|--------------------------|------------------------------|---------------------------------|
| R 0 - R 5 500 monthly | R 5 501 - R 8 500 monthly | R 8 501 and above monthly |
|--------------------------|------------------------------|---------------------------------|

* Provide **proof of income** (3 months' payslips or bank statements - not older than 3 months).
Please note that you will be registered on the highest bracket, pending proof of income.

† **Take note: Members on any of the BeatN options enjoy an efficiency discount. As such, please note that by selecting one of the BeatN options you acknowledge and agree to the following conditions:**

- I am limited to a hospital network and designated service providers as determined by the Scheme.
- I am aware of the location of the nearest above-mentioned network hospital providers.
- 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.
- 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.

‡ **Members on a Rhythm option are restricted to the contracted Rhythm designated service provider network. By selecting a Rhythm option you acknowledge and agree that your option is subject to the following:**

- GP network
- Specialist network (Referral required from network GP)
- Hospital network

4. CONSENT PROVISIONS BY APPLICANT

Table with 1 row and 12 empty columns, preceded by the letter 'I'.

- 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")...
1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy...
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...
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...
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...
1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.
2. 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...
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...
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.

Form with two buttons labeled 'Yes' and 'No'.

Empty rectangular box for signature.

Signature of member

5. APPLICATION AND DECLARATION

Please note that option changes may only be made effective from 1 January of a financial year, provided that the request is received before 31 December. I understand the benefits of my new option choice and accept the option change on my membership profile.

Signed by me

 on this

 day of

 month

Signature of principal member

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