

1. APPLICANT (PRINCIPAL MEMBER)

Membership number

Surname

Initials ID number

Current employer

Employee number

2. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Email address

Telephone number (w) Cell phone number

Physical address

Postal code

3. BENEFIT OPTION

Benefit option (indicate with 'X')

Beat1	<input type="checkbox"/>	Beat1N (Network) †	<input type="checkbox"/>	Pace1	<input type="checkbox"/>
Beat2	<input type="checkbox"/>	Beat2N (Network) †	<input type="checkbox"/>	Pace2	<input type="checkbox"/>
Beat3	<input type="checkbox"/>	Beat3N (Network) †	<input type="checkbox"/>	Pace3	<input type="checkbox"/>
Beat3 Plus	<input type="checkbox"/>			Pace4	<input type="checkbox"/>
Beat4	<input type="checkbox"/>				

Rhythm1 * ‡ Rhythm2 * ‡

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
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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
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* 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.

† **Members on any of the BeatN options enjoy an efficiency discount. By selecting one of the BeatN options you acknowledge and agree to the following conditions:**

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

‡ **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:**

1. GP network
2. Specialist network (Referral required from network GP)
3. Hospital network

- 4.15 To identify other products and services which might be of interest to us, as well as to inform us of such products and/or services.
 - 4.16 To obtain and share information about our credit worthiness with any credit bureau or credit provider's industry association or industry body, which includes information pertaining to our credit history, financial history, judgements, default history and sharing information for purposes of risk analysis, tracing and related purposes.
5. In as far as we provide Bestmed with the Personal Information of any third party, including the Personal Information of our employees, their spouse(s), children or other dependants, we hereby warrant that we have acquired the consent of such third party to do so and that we are a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

The representative acting on our behalf herein and facilitating the submission of this application to Bestmed, warrants that he/she is duly authorised to act on our behalf and to thereby bind us to the terms and conditions related to this application.

Signature of employer

HR practitioner details

Employee number

Surname

Full names

Email

Telephone number

Remarks

Signature of HR practitioner

Date

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Name stamp of employer