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Instructions

Complete and sign the application form and fax cover sheet and fax it to 086 248 4524.
Alternatively scan and email to us at info@medicalaidonline.co.za
We will contact you shortly thereafter to discuss the status of your application.

Thank you for choosing Medical Aid Online.

FAX COVER SHEET

To:	Medical Aid Online	**From:**	.....
Fax no:	086 248 4524	**Tel no:**	.....
		Date:	.....
Comments:		**Pages:**	.....

.....

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.....

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No 6 Robin Drive, Fourways P O Box 70687 . Bryanston . 2021
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An authorised financial services provider. FSP36088

Directors: AJ Smart | AA Graham

APPLICATION FOR INDIVIDUAL MEMBERSHIP
AANSOEK OM INDIVIDUELE LIDMAATSKAP

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

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 M F

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

Monthly gross income
Maandelikse bruto inkomste R _____

Current employer
Huidige werkgewer _____

Period employed
Tydperk in diens _____

Please provide proof of income or 3 months bank statements for options, Pace 3 and Pulse 1.
Asseblief Bewys van inkomste of 3 maande se bankstate vir opsies, Pace 3 en Pulse 1.

Benefit option Voordeelopsie		Benefit option Voordeelopsie		Benefit option Voordeelopsie	
Beat1♥		Pace1♥		Pace4♥	
Beat2♥		Pace2♥		*Pulse1♥	
Beat3♥		Pace3♥		Pulse2♥	

***If Pulse1, please indicate the following / Indien Pulse1 dui asseblief die volgende aan:**
General Practitioner Choice
Algemene Praktisyn Keuse

Name of Naam van	General Practitioner Algemene Praktisyn	Practice number Praktyknommer
Principal Applicant Hoof Aansoeker		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		
Dependant Afhanklike		

Sections 1-9 to be completed by applicant
Afdelings 1-9 moet deur die aansoeker voltooi word

2. 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.

3. 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
- '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

4. 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 _____

Send starter pack to
Stuur beginpak na _____

Fax
Faks _____

E-mail
E-pos _____

Tel (w) _____

Tel (h) _____

Cell
Sel _____

Total member cards
Aantal lidkaarte ☐

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

Please complete the following and note that a CERTIFICATE OF MEMBERSHIP for every person for all membership should accompany the application form (NB: Not a member card)

Voltooi asseblief die volgende en neem kennis dat 'n SERTIFIKAAT VAN LIDMAATSKAP vir elke persoon vir alle lidmaatskap hierdie aansoek moet vergesel. (LW: Nie 'n lidmaatskapkaart nie)

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

6. CLAIM REIMBURSEMENT DETAILS / EIS BETALINGS BESONDERHEDE

Account holder
Rekeninghouer _____

Bank _____

Branch name and town
Taknaam en dorp _____

Account number
Rekeningnommer | | | | | | | | | | | | | | | | | | | |

Branch number
Taknommer | | | | | | |

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: Copy of a bank statement to be attached. Nota: Afskrif van ´n bankstaat moet aangeheg word.

7. MEDICAL HISTORY OF APPLICANT AND DEPENDANT(S) / MEDIESE GESKIEDENIS VAN AANSOEKER EN AFHANKLIKE(S)

Name of Naam van	Length Lengte (in cm)	Weight Gewig (in kg)	BMI LMI
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 toestand 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.

8. 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

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 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 medical 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 hierbo 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 mediese 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 indien dit aan die lig sou kom dat valse inligting willens en wetens met aansoek verskaf is.

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.

Signature of Healthcare Advisor/Handtekening van Gesondheidsorg-adviseur

10. SUMMARY OF MONTHLY COST / OPSOMMING VAN MAANDELIKSE KOSTES

1. Total high risk premium (principal member or principal member and spouse/partner and child dependant/s)
   (*Emergency evacuation included)*
   Totale hoërisikopremie (hooflid of hooflid en gade/metgesel en kinderafhanklike/s)
   (Noodontruiming ingesluit) R _____

2. Total monthly savings account
   Totale maandelikse mediese spaarrekening R _____

3. Extended family (including monthly savings)
   Uitgebreide familie(ingesluit maandelikse spaarrekening) R _____

MONTHLY TOTAL (1-3)
MAANDELIKSE KOSTE (1-3) R _____

Signature of applicant/Handtekening van aansoeker

Signature of witness/Handtekening van getuie

Healthcare Advisor name
Naam van Gesondheidsorg-adviseur Alexia Graham

Healthcare Advisor code
Gesondheidsorg-adviseurkode | T | J | G | I | 0 | 1 | G | 0 | I | F Z P

A.Graham
Healthcare Advisor signature/Handtekening van Gesondheidsorg-adviseur

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

DEBIT ORDER-BESTMED CONTRIBUTIONS
DEBIETORDER-BESTMED BYDRAE

bestMed
Better living. Better life.

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

Title
Titel _____ Surname
Van _____

Residential address
Residensiële adres _____

_____

Occupation
Beroep _____

Employer
Werkgewer _____ Period in Service
Periode in Diens _____

2. CALCULATION OF MONTHLY DEBIT ORDER / BEREKENING VAN MAANDLIKSE DEBIETORDER

Name of benefit option
Naam van voordeelopsie _____

TOTAL MONTHLY SUBSCRIPTION
TOTAAL MAANDELIKS SUBSKRIPSIE R _____

3. DETAILS OF BANK ACCOUNT

Account holder
Rekeninghouer _____

Branch name
Taknaam _____ Bank _____

Account number
Rekeningnommer | | | | | | | | | | |

Branch number
Takkode | | | | | | |

Type of account
Tipe rekening Cheque / Tjek | Savings / Spaar

Day of debit order
Dag van debietorder 20th/20ste | 25th/25ste | 1st/1ste

***Or the first working day there after**
***Of die eerste werksdag daarna**

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 sum of R _____ on the first working day on or after the above mentioned dates, commencing on _____ . I/we further authorise Bestmed to adjust the amount due as fees are amended from time to time. All such withdrawals from my/our account by Bestmed shall be treated as though they have been signed by me/us personally. I/we agree to pay bank charges relating to this debit order instruction. This authority may be cancelled by me/us by giving Bestmed 60 days' notice in writing, sent by prepaid registered post, provided that this may not be done within 12 calendar months without the written permission of Bestmed. Should there be a breach of this contract there is a possibility that the member will be held responsible for payments incurred. I/we understand that I/we shall not be entitled to any refunds of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Bestmed. I/we acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorised party.

Ek/ons magtig hiermee Bestmed om geld te onttrek uit my/ons rekening by die bogenoemde bank (of enige bank of tak waarna ek/ons my/ons rekening oorplaas) ten bydrae van R _____ (op die eerste werksdag van bogemelde datum met ingang) _____ . Ek/ons bemagtig Bestmed verder om die bedrag aan te pas soos wat die ledegelde van tyd tot tyd verander. Alle sodanige onttrekkings van my/ons rekening sal geag word asof deur my/ons persoonlike geteken. Ek/ons onderneem om bankkostes gekoppel aan hierdie debietorder te betaal. Ek/ons mag hierdie magtiging kanselleer deur Bestmed 60 dae skriftelik kennis te gee, op voorwaarde dat dit nie gedoen mag word binne 12 kalendermaande sonder skriftelike toestemming van Bestmed nie. Indien daar kontrakbreuk sou wees, bestaan die moontlikheid dat die lid aanspreeklik gehou sal word vir kostes aangegaan. Indien bydrae wettiglik verskuldig was aan Bestmed, verstaan ek/ons dat ek/ons nie geregtig sal wees op enige terug betaling van bydrae wat onttrek is terwyl hierdie magtiging van krag was nie. Ek/ons bevestig dat die onttrekking teen my/ons rekening nie deur die gemagtigde party gesedeer mag word en dat die gemagtigde party nie enige van sy regte mag oordra na 'n derde party sonder my/ons vooraf skriftelike toestemming nie en dat ek/ons nie enige verligtinge ingevolge hierdie kontrak/magtiging aan enige derde party delegeer sonder vooraf skriftelike toestemming van die derde party nie.

_____ _____
Signature of principal member/Handtekening van hooflid Signature of account holder/ Handtekening van rekeninghouer

Signed at
Geteken te _____ on the
op die _____ day of
dag van _____ 20__

Please note: Copy of bank statement to be attached.
Nota: Afskrif 'n bankstaat moet aangeheg word.