CONSENT FOR THE SHARING OF PERSONAL/SPECIAL PERSONAL INFORMATION

As defined in the Protection of Personal Information Act, 4 of 2013

By completing sections 1 or 2 of this form, you allow Bestmed Medical Scheme to share the specified Personal/Special Personal Information with the nominated party(ies) indicated in the applicable sections of the form.

Examples of the information that will be available to the nominated party

Biographical information	Benefit information	Financial information	Medical information
▪ Membership number ▪ Date of birth ▪ ID number ▪ Postal address ▪ Residential address ▪ Email address ▪ Contact numbers	▪ Benefit option ▪ Available medical savings account balance ▪ Available benefits ▪ Limits on benefit option ▪ Waiting period information	▪ Monthly subscription ▪ Tax certificate ▪ Membership certificate ▪ Balance due or outstanding	▪ Chronic or prescribed minimum benefit conditions details ▪ Status of authorisations ▪ Claim transaction history ▪ Medication used ▪ Medical procedures performed as well as procedure codes

1. CONSENT BY THE MEMBER (INSTRUCTOR)

By completing this section, you provide consent to the nominated party, i.e. member or dependant, to have access to access your Personal/Special Personal Information, as listed in the examples above.

I,
Title | Initials | Membership number

Full name

Surname

ID/Passport number

Country of issue

Email address

Cellphone number

hereby nominate:

1. Consent by the member to a Bestmed registered beneficiary (i.e. member or dependant) with whom we may share the specified Personal/Special Personal Information, as listed in the examples above.

Membership number | Beneficiary number

Name

Surname

Relationship to member | Date of birth (D D M M Y Y Y Y)

ID/Passport number

Country of issue

Email address

Cellphone number

Bestmed Medical Scheme is an Authorised Financial Services Provider (FSP no. 44058)
Consent for the Sharing of Personal Information as defined in the POPIA Act Form
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2. Consent by member to a nominated third party or next of kin. By completing this section, you, the member provide permission to the nominated third party or next of kin (not registered under the Bestmed profile) to access the specified Personal/Special Personal Information, as listed above, of all registered beneficiaries.

Relationship to member

Name

Surname

ID/Passport number

Country of issue

Email address

Cellphone number

Date of birth D D M M Y Y Y Y

2. CONSENT BY A REGISTERED DEPENDANT (INSTRUCTOR)

1. By completing this section, you as the dependant, who is 18 years or older, provide permission to the registered beneficiary (i.e. member or dependant) to access your Specified Personal/Special Personal Information, as listed in the examples above.

Fill out the detail of the dependant who gives the consent here.

I,

Membership number

Beneficiary number

Name

Surname

Relationship to member

Date of birth D D M M Y Y Y Y

ID/Passport number

Country of issue

Email address

Cellphone number

hereby nominate and appoint:

2. Fill out the details of the person to whom the consent is given to access the specified Personal/Special Personal Information, as listed in the examples above.

Membership number

Beneficiary number

Name

Surname

Relationship to member

Date of birth D D M M Y Y Y Y

ID/Passport number

Country of issue

Email address

Cellphone number

3. TERMS AND CONDITIONS ON THE CONSENT

to be completed by the instructor and the nominated party

1. I hereby give informed consent for Bestmed to share my Personal/Special Personal Information, as defined in the Protection of Personal Information Act, 4 of 2013 ("POPIA") with the duly nominated party(ies).
2. I acknowledge that my Personal/Special Personal Information includes, but is not limited to my health, medical and treatment records.
3. I confirm that I understand that the Personal/Special Personal Information that may either be obtained from or disclosed to the duly nominated party(ies) may include the Personal/Special Personal Information of my dependants in the case of the member.
4. I agree that Bestmed will not be held liable for any loss, including direct, indirect, and consequential loss, or claims resulting from the wrongful or unauthorised use of shared Personal/Special Personal Information, that may arise from any disclosure contemplated herein.
5. I am aware that Bestmed subcontracts certain services to third parties and, as a result, I indemnify any subcontracted service provider of any liability relating to privacy where the sharing of information relates to the provision of healthcare services in terms of the Medical Schemes Act.
6. I agree that once consent is provided, all data listed in the examples above will be provided to the duly nominated party(ies).
7. This consent will be in force until expressly withdrawn in writing by the instructor.
8. This consent will become null and void in the event of the death of a member or dependant providing consent and a new consent form shall be completed by the executor appointed.
9. Bestmed will only share the information with the duly nominated party(ies) and will not accept any instructions with regard to changes and/or updates to the profile from any of the nominated parties.

Name of instructor

Signature of instructor

Date D D M M Y Y Y Y

1. Name of nominated party

1. Signature of nominated party

Date D D M M Y Y Y Y

2. Name of nominated party

2. Signature of nominated party

Date D D M M Y Y Y Y