NASA

The Neurological Association of South Africa

P O Box 2127, Cresta, 2118
Unit 16 Northcliff Office Park
203 Beyers Naude Drive
Northcliff, 2115
Tel: 011 340 9000
Fax: 011 782 0910
www.mynasa.co.za
E-mail: neurology@healthman.co.za

Please allow for a maximum of 5-7 working days, from date of receipt for your application to be finalised

MEMBERSHIP APPLICATION

I, the undersigned _____ hereby apply to take up membership in The Neurological Association of South Africa (the Association), the object of which is to negotiate with the funders of health care, managed care organisations, health care providers, suppliers of goods and services to members of the Association and with any other relevant parties, with a view to maximising potential synergistic and rationalisation benefits for individual members and the Association. I acknowledge that the Constitution of the Association are available for my inspection and I agree that the NASA Executive may use my medical claims data specifically and exclusively in order to benefit all members of the Association as a group.

SIGNED at_____ this _____day of _____20____.

Signature: _____

NOTE:
Membership information, to be completed by the applicant (or each partner in the event of a group practice). The information below is necessary in order to prepare a complete members database. Please complete in full. Retain a copy for your records. The majority of communications is by e-mail, WhatsApp and sms notifications.

How did you hear about us?

TITLE	
SURNAME	
FIRST NAMES	
KNOWN AS	
POSTAL ADDRESS	
PRACTICE NAME	
PRACTICE / PHYSICAL ADDRESS	
Date of Birth	

Sponsors require us to indicate the following fields for the purposes of BBBEE certification:	PRACTICE NO (BHF/ PCNS):	HPCSA REGISTRATION NO:
ID NUMBER:		
GENDER:		
RACE:		

VAT REGISTRATION NO:	EMAIL ADDRESS:

PRACTICE TELEPHONE NO:	PRACTICE FAX NO:	CELLULAR NO:

PRACTICE MANAGER	Full Name:	
	Email Address:	
MEMBERSHIP TYPE	Private Practice	☐ R597.00
	Public Service	☐ R227.00
	Registrar	☐ R72.00
	Overseas	☐ Free

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Written Authority and Mandate for Debit Payment Instructions

This signed Authority and Mandate refers to our contract dated _____ ("the Agreement").
I/We hereby authorise you to issue and deliver payment instructions to your Banker for collection against my/our above-mentioned account at my/our above-mentioned Bank (or any other bank or branch to which I/we may transfer my/our account) on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on _____ and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address as indicated above.
The individual payment instructions so authorised to be issued must be issued and delivered monthly.
In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Payment Instructions due in December may be debited against my account on _____*NA*_____*(date).*
I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a reference number which is your practice number, which must be included in the said payment instruction and if provided to me should enable me to identify the Agreement.
Mandate: I/We acknowledge that all payment instructions issued by you shall be treated by my/our below-mentioned Bank as if the instructions have been issued by me/us personally.
Cancellation: I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.
Assignment: I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.
You will be notified within 30 days of the next debit order payment of any fee increases for your membership.
Your debit order will then automatically be adjusted to reflect these increases.
Please note: Apart from the first month of your membership and the month of December, your debit orders will be set to go off in the beginning of every month, dependent on weekends and public holidays.

Payment to (Company name) Registered abbreviated company name	***HEALTHMAN***
Name of account holder	
Address of account holder	
Practice number	
Banking details	
Name of Bank	Type of Account
Branch Name	Branch code
Account number	Monthly amount: □R597 □R227 □R72

Signed at _____ on this _____day of _____

_____
(Signature as used for operating on the account)

Please attach a cancelled cheque/ proof of banking details. Please ensure you complete the membership application form AND the written authority for debit order payment instructions.

Please fax back to 011 782 0910 or email *neurology@healthman.co.za*

STATEMENT OF CONSENT TO

DATA PROCESSING

(In terms of the provisions of the Protection of Personal Information Act)

1. I, _____(full names of Society/Group member), ID number _____("the member")

   hereby grant **my consent to**_____("Society/Group") and their appointed *processor* to process my personal data for the purpose of any or all of the undermentioned actions, being the legitimate reasons *for processing and/or using my personal data;*

2. I accept that my personal information will only be utilized for the purpose it was collected, that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time, as well as request correction or deletion of my personal Information held by the Society/Group;

3. I the undersigned furthermore warrant that such information is accurate, relevant, up to date and complete and I undertake to advise Society/Group in writing of any material change of such information.

4. I am aware that I may withdraw my consent at any time by using the relevant Data Subject Consent Withdrawal Form.

5. I can opt out of receiving communications. However, communications regarding my profile and account cannot be opted out of.

Signed by the member: _____

Date: _____

Authorised actions:

- To collect and have access to my personal information.
- To process my personal information (both terms as defined in the Protection of Personal Information Act, Act 4 of 2013 ["POPI"), which processing includes amongst others the 'collecting, storing and dissemination' of my personal information (as defined in POPI) for the purpose of rendering services to me;
- Share my personal information with third parties who provide services ancillary to the services I have obtained and will obtain from the Society/Group;
- To allow my Society/Group's administrator, HealthMan, and its employees and contractors access to my personal information for the purposes of rendering services to me.
- To use my personal information to communicate with me in person/via telephone/email/video call/fax/WhatsApp/any form of social media.