

# APPLICATION FOR EX GRATIA ASSISTANCE

## INSTRUCTIONS:

It is imperative that all sections of this application form be completed in full. Failure to do so may cause a delay in the processing of the application. Should you require assistance with completing this form, please contact the BP Medical Aid Society on **021 480 4610** or **0800 001 607**. Once completed, please post, fax or e-mail the application form to the details provided at the end of the form.

## TO BE COMPLETED BY APPLICANT

### MEMBER DETAILS:

MEMBERSHIP NUMBER

SURNAME

TITLE  INITIALS  AGE

E-MAIL ADDRESS

ARE YOU AN EMPLOYEE  OR CONTINUATION MEMBER (PENSIONER/RETIREE)

### PATIENT DETAILS (IF NOT THE MAIN MEMBER):

NAME AND SURNAME

TITLE  AGE  ID NUMBER OR DATE OF BIRTH

ADDRESS

E-MAIL ADDRESS

TELEPHONE   (H)   (W)  
  (CELL)

## CRITERIA FOR APPLICATION

All applications must be accompanied by a detailed doctor's motivation, which must include the following information:

- ▶ Diagnosis
- ▶ Medical history of patient
- ▶ Treatment plan and medication required (attach detailed quotations from medical practitioner or service provider)

## MEMBER MOTIVATION

Please outline the nature of the assistance required and reasons for seeking assistance.

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## DECLARATION BY APPLICANT

Yes, I have a major medical policy

No, I do not have any major medical policies

If YES, to what extent will it cover your expenses?

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I confirm that I have approached my medical service provider to obtain some relief by way of an adjusted fee or tariff to meet the additional costs (please insert name(s) of parties concerned).

Doctor \_\_\_\_\_

Hospital \_\_\_\_\_

Contact person at hospital \_\_\_\_\_

Other service provider \_\_\_\_\_

The outcome was as follows:

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If the account was reduced or payment terms agreed upon, please indicate and provide details.

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I \_\_\_\_\_, the undersigned, hereby certify that the information stated in this document is true and correct.

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MEMBER'S SIGNATURE

D	D	M	M	Y	Y	Y	Y
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DATE

**RETURN ADDRESS:** BP MEDICAL AID SOCIETY, EX GRATIA DEPARTMENT, PO BOX 5324, CAPE TOWN 8000  
FAX: 021 480 4616 | E-MAIL: [bpmas@mhg.co.za](mailto:bpmas@mhg.co.za)