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 **0800 001 607** (SA) or **+27 21 480 4610** (Namibia). Once completed, please post, fax or email the application form to the details provided below.

Post: BP Medical Aid Society, Ex Gratia Department, PO Box 5324, Cape Town 8000
Fax: 021 480 4616
Email: enquiries@bpmas.co.za

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS.

TO BE COMPLETED BY THE APPLICANT

MEMBER DETAILS

Membership number

Title | Initials | Age

Surname

First name

Email address

Are you ☐ an employee **or** ☐ continuation member (pensioner/retiree)?

PATIENT DETAILS (IF NOT THE MAIN MEMBER)

Identity/Passport number

Title | Initials | Age

Surname

First name

Contact number (home) | (work)

Cell phone number

Postal address

Postal code

Email address

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.

FINANCIAL INFORMATION (THIS SECTION MUST BE COMPLETED IN FULL)

Please attach the following documents:

- A copy of your latest pay/pension advice
- A copy of your spouse's latest pay/pension advice

FINANCIAL STANDING

What is your monthly income?

	Principal member	Spouse
Net salary	R	R
Net pension	R	R
Dividends	R	R
Interest on investments	R	R
Part-time work	R	R
Other (specify below)	R	R
Total monthly income	**R**	**R**

If you have indicated that you receive monthly income from other sources, please specify:

ASSETS AND LIABILITIES

Assets	Estimated value
Residential property owned	R
Other properties (supply details on page 3)	R
Share and investments	R
Cash in bank	R
Furniture	R
Vehicles	R
Other significant assets	R
Total	**R**

Liabilities	Estimated value
Residential property (mortgage bond)	R
Other properties (mortgage bond)	R
Loans overdraft	R
Bank overdraft	R
Creditors	R
Vehicles	R
Other significant liabilities	R
Total	**R**

FINANCIAL INFORMATION (THIS SECTION MUST BE COMPLETED IN FULL) (CONTINUED)

ASSETS AND LIABILITIES (CONTINUED)

Details of other properties, if applicable:

MONTHLY EXPENSES (PLEASE ITEMISE YOUR EXPENSES IN BROAD CATEGORIES)

Expenses	Amount
Rent/Bond/Levies	R
Medical aid	R
Credit card	R
School fees	R
Maintenance	R
Loan repayments	R
Transport	R
Clothing	R
Entertainment	R
Water and electricity	R
Rates and taxes	R
Telephone	R
TV licence/M-Net, etc.	R
Groceries/Meat/Toiletries/Cleaning materials	R
Hire purchase, e.g. furniture, vehicle	R
Assurance: Life	R
Assurance: Endowment	R
Assurance: Retirement	R
Insurance: Household	R
Wages: Domestic	R
Wages: Gardener	R
Other	R
Total monthly expenditure	**R**

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?

DECLARATION BY APPLICANT (CONTINUED)

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.

Doctor	
Hospital	
Contact person at hospital	
Other service provider	

The outcome was as follows:

If the account was reduced or payment terms agreed upon, please provide details below:

I understand and accept that during my membership of the Society both personal and clinical information relating to me and my dependants, as beneficiaries, will be disclosed to the Society, as well as the Administrator and/or managed care provider and form part of the records of the Society.

I hereby authorise the Society and its Administrator and/or managed care provider to provide such personal and/or clinical information relating to me and/or my dependants under the age of 18, including any authorisations, to the Society's contracted designated service providers and/or other third parties, provided that such information will only be used for the purposes of:

- considering this application;
- the payment of any claims relating to benefits payable under the Society rules;
- the granting of any approvals and/or authorisations, including those relating to hospital admission and/or the participation in any managed care programmes which the Society has contracted to be provided to beneficiaries.

I also undertake to take all such steps as to ensure that any dependant over the age of 18, or younger, as may be required by law, also provide their written consent to the disclosure of any such information.

DECLARATION BY APPLICANT (CONTINUED)

This consent is provided on the clear understanding that:

1. the designated service providers and/or any third parties will be bound by the same confidentiality agreement as exists between the Society and its Administrator and/or its managed care provider, as well as their employees relating to the confidentiality of such information;
2. this information will be provided solely for the purposes of providing relevant healthcare and/or managed healthcare services and/or benefits to myself and/or my dependants;
3. wherever reasonably possible, such information is to be anonymised or encrypted.

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

Signature _____ Date _____

DD/MM/YYYY