

## 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**. Once completed, please email the application form to [exgratia@bpmas.co.za](mailto:exgratia@bpmas.co.za).

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS.

### TO BE COMPLETED BY THE APPLICANT

#### MEMBER DETAILS

Membership number	<input type="text"/>		
Title	<input type="text"/>	Initials <input type="text"/>	Age <input type="text"/>
First name	<input type="text"/>		
Surname	<input type="text"/>		
Email address	<input type="text"/>		
Are you	<input type="checkbox"/> an employee	or	<input type="checkbox"/> continuation member (pensioner/retiree)?

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

Identity/Passport number	<input type="text"/>		
Title	<input type="text"/>	Initials <input type="text"/>	Age <input type="text"/>
First name	<input type="text"/>		
Surname	<input type="text"/>		
Contact number (home)	<input type="text"/>	(work)	<input type="text"/>
Cell phone number	<input type="text"/>		
Physical address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Code	<input type="text"/>
Email address	<input type="text"/>		

### 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
Rental income	R	R
Part-time work	R	R
Other (specify below)	R	R
<b>Total monthly income</b>	<b>R</b>	<b>R</b>

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
Shares and investments	R
Cash in bank	R
Furniture	R
Vehicles	R
Other significant assets	R
<b>Total</b>	<b>R</b>

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
<b>Total</b>	<b>R</b>

## 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
<b>Total monthly expenditure</b>	<b>R</b>

## DECLARATION BY APPLICANT

I and/or my dependants have claims lodged against the Road Accident Fund.

Yes  No

I and/or my dependants have claims lodged against Workers' Compensation.

Yes  No

I have supplementary insurance (e.g. gap cover) for protection against shortfalls not covered by the Society.

Yes  No

If 'yes', to what extent will the supplementary insurance 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

04/2026