POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

Application for Ex Gratia Assistance

IMPORTANT:
1. It is compulsory to complete all sections of this form to prevent delays in processing your application.
2. Please keep copies of all documentation.
3. Attach supporting documentation e.g. account of service provider, receipt if account is paid by member.

DISCLAIMER: Ex Gratia approval is not guaranteed, but subject to assessment based on clinical protocols. The rate of reimbursement will be between 80% and 100% of the POLMED rate. Completion of the form by the doctor will be reimbursed at 80% of POLMED rates if no benefits are left.

Member Details

Membership Number

Surname

First Name (in full)

Title/Rank Initials Number of Dependants

Identity Number Date of Birth D D M M Y Y Y Y

Occupation

Contact Details

Address

Code

Telephone (Home) Telephone (Work)

Cellphone Fax

Email

Motivation by Medical Practitioner relating to Ex Gratia request

Diagnosis (or attach doctor's detailed letter of motivation and photograph)

Medical History

Continued

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Application for Ex Gratia Assistance

Motivation by Medical Practitioner relating to Ex Gratia request - Continued

Doctor's Signature _____

Details of Ex Gratia Assistance

Please state the details of your medical claims.

Type of illness
Dependant ☐ _____
Dependant ☐ _____
Dependant ☐ _____

Suppliers of medical services relating to ex Gratia

1. Provider's Name
   Practice Number
   Ex Gratia application amount R
2. Provider's Name
   Practice Number
   Ex Gratia application amount R
3. Provider's Name
   Practice Number
   Ex Gratia application amount R
4. Provider's Name
   Practice Number
   Ex Gratia application amount R
5. Provider's Name
   Practice Number
   Ex Gratia application amount R

Signature of Member _____

Date D D M M Y Y Y Y

RETURN ADDRESS: Hand it in at any one of the Medscheme walk-in branches
Fax: 0860 104 114 Email: polmedspecialcases@medscheme.co.za
Private Bag X16, Arcadia, 0007