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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.**

PLEASE NOTE: That Ex Gratia approval will be based on income bands.

DISCLAIMER: Ex Gratia approval is not guaranteed, but subject to assessment based on clinical protocols.

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: polmedexgratia@medscheme.co.za
Private Bag X16, Arcadia, 0007