

## **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.

| Member Details                  |   |
|---------------------------------|---|
| Membership Number               |   |
| Surname                         |   |
| First Name (in full)            |   |
| itle/Rank                       | Initials Number of Dependants   |
| dentity Number                  | Date of Birth DDMMYYYY  |
| Occupation                      |   |
| Contact Details                 |   |
| Address                         |   |
| elephone (Home)                 | Telephone (Work)  |
| Cellphone                       | Fax   |
| Email                           |   |
| <b>Diagnosis (</b> or attach do | edical Practitioner relating to Ex Gratia request octor's detailed letter of motivation and photograph) |
|                                 |   |

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## **Application for Ex Gratia Assistance**

| Ooctor's Signature |                                |
|--------------------|--------------------------------|
|                    |                                |
| etails of Ex Gr    | ratia Assistance               |
|                    | ails of your medical claims.   |
| ype of illness     | Dependant                      |
|                    | Dependant                      |
|                    | Dependant                      |
|                    | ervices relating to ex Gratia  |
| Provider's Name    |                                |
| Practice Number    | Ex Gratia application amount R |
| 2. Provider's Name |                                |
| Practice Number    | Ex Gratia application amount R |
| . Provider's Name  |                                |
| Practice Number    | Ex Gratia application amount R |
| . Provider's Name  |                                |
| Practice Number    | Ex Gratia application amount R |
| 5. Provider's Name |                                |
| Practice Number    | Ex Gratia application amount R |
| Signature of Membe | er Date DDMMYYYY               |
| J 2 01 0100        |                                |

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