Annexure A

APPLICATION FOR EX GRATIA BENEFITS

……

PLEASE NOTE:

- *Submission of this form must be done according to the "Procedure and Rules Application for Ex-Gratia Awards"*
- *This application does not guarantee approval of an ex gratia award or that the Scheme will accept liability for payments. Amounts owing to service providers for which this ex-gratia application may have been submitted, remains the member's responsibility.*
- *The Ex Gratia Committee may authorise payments at their absolute discretion provided they are satisfied that medical necessity is evident and/or significant financial hardship exists.*
- *The Ex Gratia application will not be submitted to the Committee should any section of this form or Annexures be incomplete.*

……

Basis for this request *(tick a block and attach supporting documentation where necessary)*:

Financial Hardship ☐ Exceptional Circumstances ☐ Rare procedure ☐

Name Main Member: …… Name of Patient: ……

Membership No: …… Scheme join date: ……

Date of Application: …… Telephone/Fax No: ……

Postal Address: ……

No of Dependants : …… Ages of dependants: …… …… …… …… ……

INCOME & EXPENDITURE STATEMENT

MEMBER TO COMPLETE

Annexure A

Net Monthly Income (Member) : R _____

(Spouse) : R_____

Monthly Expenditure:

Bond/Rent : R _____

Municipal Rates & Taxes : R _____

Electricity & Water : R _____

Telephone : R _____

Hire Purchase Payments (s) : R _____

Insurance Premium (s) : R _____

Transport : R _____

Domestic & Garden Help : R _____

Groceries : R _____

Clothing : R _____

Other : R _____

Net Cash Surplus/Deficit : R _____

STATEMENT OF: **ASSETS** **LIABILITIES**

Value of property owned: R_____ Bond owing: R_____

Details: _____ Bank/Overdraft : R_____

Shares & Investments: R_____ Loans: R_____

Cash in bank: R_____ Debtors: R_____

Other significant assets: R_____

TOTAL R_____ TOTAL R_____

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

Signature : …… Date : ……

Annexure A

PROOF OF INCOME

Should the Pension Fund Administrator be unavailable, a copy of a recent Pension Slip/Tax Return will be acceptable in the case of Pensioner applications - alternatively please have the following completed by a Payroll Administrator.

Name of Company: ……

We confirm that: …… is/was employed by us and

receives/received a Gross Salary/Pension of R ……per month.

Length of service with company: …… years……months.

Recommendation by Employer:

……

……

……

Company/Fund Stamp:

NB: Failure to disclose full information, or submission of false statements could result in benefits being limited or excluded and/or membership being terminated.

…… ……

Signature Name in block letters

…… ……

Designation Date

Annexure A

CONFIDENTIAL MEDICAL REPORT

1. EX GRATIA APPLICATION REPORT

TO BE COMPLETED BY A MEDICAL PRACTITIONER/SPECIALIST

SHOULD THE PRACTITIONER/SPECIALIST WISH TO RETURN THIS REPORT DIRECTLY TO THE SCHEME, IT CAN BE FAXED CONFIDENTIALLY TO: 086 762 4050

How long have you been involved in the medical care of this patient*?* ……

2. DETAILS OF ADDITIONAL BENEFITS AND AMOUNTS REQUESTED (attach quotations)

3. MEDICAL HISTORY

Past Examinations/Diagnosis/Severity/Prognosis/Functional Status

4. PRESENT OCCUPATIONAL STATUS

5. LIFESTYLE / DIETARY ISSUES / ADVICE GIVEN

6. TREATMENT PLAN & MEDICATION REQUIRED

7. COMPLIANCE RELATING TO MEDICAL ADVICE OR TREATMENT

8. MEDICAL PRACTITIONER/SPECIALIST'S ASSESSMENT AS TO WHY THIS CASE SHOULD BE REGARDED AS AN EXCEPTIONAL MEDICAL CIRCUMSTANCE THAT CANNOT BE MANAGED WITHIN THE MEMBERS ALLOCATED BENEFITS

Medical Practitioner/Specialist's Name: ……

Practice No : …… Signature: …… Date:……