

EX GRATIA APPLICATION FORM

Please complete all sections and forward to the Ex Gratia Department for preparation and submission to the Ex Gratia Committee:

Postal address: Ex Gratia Department
P.O. Box 746
Rivonia, 2128
Fax number: 011 539 1021
Email address: ex-gratia@angloms.co.za

WHAT IS EX GRATIA?

Ex Gratia means “as a favour”. It is a discretionary consideration by Anglo Medical Scheme, which is only made where the Committee believes that an exceptional situation exists which warrants funding. It is not a benefit that the Scheme has to offer, nor is funding guaranteed.

HOW ARE EX GRATIA DECISIONS MADE?

Ex Gratia awards may be made by the Committee in its absolute discretion, provided it is satisfied that significant financial hardship or exceptional medical circumstances exist.

Only applications with complete information can be reviewed by the Committee. It is your responsibility to make sure that all the relevant information and supporting documentation are provided. This will be presented to the Committee.

HOW DO I APPLY FOR EX GRATIA?

The application form needs to be completed and signed by the main member. Attach all the relevant information as indicated below. The following supporting documentation will need to be provided as a minimum requirement to review your application (please tick the appropriate block to confirm it has been enclosed):

- Additional clinical information (in addition to Section 2 if requested)
- Account/s (if applicable)
- Quote/s (if applicable)
- Proof of income
- An IT3(a)/IRP5 certificate if you are employed as well as an IT3(b) certificate from an institution such as a bank or other financial services provider, summarising investment interest and dividends, and three months bank statements.

Fax the completed form and attachments to **011 539 1021** or email it to ex-gratia@angloms.co.za or post it to **P.O. Box 746, Rivonia, 2128**

IMPORTANT

- The case will not be submitted to the Committee should any section be incomplete (unless stated as not applicable)
- Financial disclosure is obligatory
- Please note that all documentation should be submitted one month before the meeting as the cut off for preparation is two weeks before a scheduled meeting date.

PLEASE PROVIDE A SHORT SUMMARY OF YOUR REQUEST WITH THE EXCEPTIONAL CIRCUMSTANCES TO BE CONSIDERED

Basis of request: (please tick) Financial hardship Exceptional circumstances Both
 Benefit Option: (please tick) Managed Care Plan Standard Care Plan Value Care Plan

1. MEMBER INFORMATION

Membership number

Main member name

Name of patient

Number of dependant/s Age of dependant/s

Join date on Scheme

Y	Y	Y	Y	M	M	D	D
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Join date on Plan

Y	Y	Y	Y	M	M	D	D
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Telephone (H) (W)

Cellphone Fax

P.O. Box

Postal code

Email address

2. MEDICAL REPORT TO BE COMPLETED BY PRACTITIONER

2.1. Diagnosis:

2.2. Medical and surgical history:

2.3. Treatment plan and medication required:

2.4. Healthcare provider's assessment and exceptional circumstances to consider:

3. HEALTHCARE PROVIDER DETAILS

Healthcare provider name

Practice number

Contact number

Signature

2 0 Y Y M M D D

4. MEMBER – FINANCIAL DISCLOSURE

Income and expenditure	Value
4.1. Monthly income after tax	
Salary/pension (combined family Income)	R
Other income	R
Total combined income (A)	R
4.2. Monthly expenditure	
Bond/rent	R
Loan repayments	R
Municipal rates and taxes	R
Water and electricity	R
Medical Aid contributions (if paid by member)	R
Insurance premiums	R
Children's education	R
Hire purchase repayments (please specify)	
1.	R
2.	R
Groceries	R
Domestic assistance	R
Telephone	R
Transport/petrol	R
Other expenditure (please specify)	
1.	R
2.	R
Total expenditure (B)	R
Net combined income (A - B)	R
Statements of assets and liabilities	
4.3. Assets (please specify)	
Residential property/properties	
1.	R
2.	R
Shares and investments (please specify)	
1. Shares	R
2. Investments	R
3. Other	R
Total assets	R
Total liabilities	R
Bank overdraft/other	R

STATEMENT BY MEMBER

I, agree that by applying for Ex Gratia, I

(first name and last name)

- Accept that the Committee's decision is made according to the merits of each individual case and may not be used to justify a similar decision in future
- Accept any decision the Committee makes is based on the information I have supplied
- Declare that the information I have supplied on this application form is true and, to the best of my knowledge, complete
- Authorise the Scheme to obtain and disclose any medical information and history it may require in order to consider and process this application.

Signed at (town or city) on

2	0	Y	Y	M	M	D	D
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Signature of main member The main member must sign and date any changes