APPLICATION FORM
EX GRATIA ASSISTANCE

INSTRUCTIONS:
It is imperative that all sections of this application form be completed in full. Failure to do so may cause a delay in the processing of the application. Should you require assistance with completing this form, please contact the BP Medical Aid Society on **021 480 4610** or **0800 001 607**. Once completed, please post, fax or e-mail the application form to the details provided at the end of the form.

TO BE COMPLETED BY THE APPLICANT

MEMBER DETAILS:

Membership number

Surname

Title Initials Age

Email address

Are you An employee Or continuation member (pensioner/retiree)?

PATIENT DETAILS (IF NOT THE MAIN MEMBER):

Surname

First name Title

Age ID number or date of birth

Address

Email address

Telephone (H) (W)

(Cell)

CRITERIA FOR APPLICATION

All applications must be accompanied by a detailed doctor's motivation, which must include the following information:
» Diagnosis
» Medical history of patient
» Treatment plan and medication required (attach detailed quotations from medical practitioner or service provider)

MEMBER MOTIVATION

Please outline the nature of the assistance required and reasons for seeking assistance.

DECLARATION BY APPLICANT

☐ Yes, I have a major medical policy ☐ No, I do not have any major medical policies

If YES, to what extent will it cover your expenses?

I confirm that I have approached my medical service provider to obtain some relief by way of an adjusted fee or tariff to meet the additional costs (please insert name(s) of parties concerned).

Doctor

Hospital

Contact person at hospital

Other service provider

The outcome was as follows:

If the account was reduced or payment terms agreed upon, please indicate and provide details.

I understand and accept that during my membership of the Society both personal and clinical information relating to me and my dependants, as beneficiaries, will be disclosed to the Society, as well as the Administrator and/or managed care provider and form part of the records of the Society.

I hereby authorise the Society and its Administrator and/or managed care provider to provide such personal and/or clinical information relating to me and/or my dependants under the age of 18, including any authorisations, to the Society's contracted designated service providers and/or other third parties, provided that such information will only be used for the purposes of:

» considering this application;
» the payment of any claims relating to benefits payable under the Society rules;
» the granting of any approvals and/or authorisations, including those relating to hospital admission and/or the participation in any managed care programmes which the Society has contracted to be provided to beneficiaries.

I also undertake to take all such steps as to ensure that any dependant over the age of 18, or younger, as may be required by law, also provide their written consent to the disclosure of any such information.

This consent is provided on the clear understanding that:

1. the designated service providers and/or any third parties will be bound by the same confidentiality agreement as exists between the Society and its Administrator and/or its managed care provider, as well as their employees relating to the confidentiality of such information;
2. this information will be provided solely for the purposes of providing relevant healthcare and/or managed healthcare services and/or benefits to myself and/or my dependants;
3. wherever reasonably possible, such information is to be anonymised or encrypted.

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

Member's signature	D D M M Y Y Y Y	Membership number
	Date	

02/14 L3902

Return Address: BP Medical Aid Society, Ex Gratia Department, PO Box 5324, Cape Town 8000
Fax 021 480 4616 **Email** bpmas@mhg.co.za