MEDSHIELD
medical scheme

EX GRATIA / SPECIAL CASES APPLICATION FORM

Email: exgratia@medshield.co.za

Ex Gratia is a discretionary consideration. This is applicable if the Scheme believes that an exceptional situation exists that warrants funding. *It is not a benefit that the Scheme has to offer, nor is it guaranteed.*

Special Cases include cases such as breast reductions, kyphoplasties and bariatric surgery procedures which are excluded from the Scheme Rules including out of formulary medications (list of specified medicines) but can be reviewed if clinically motivated. This process also applies to cases where a member's dispute declined authorisation requests.

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

- The case will not be submitted to the Committee, should any section of the application be incomplete unless stated as "not applicable".
- It is important to note that your completion of this application form in no way implies that you will receive an Ex Gratia award, or that Medshield Medical Scheme accepts any liability whatsoever for any amounts that you owe to any registered medical service providers. Any such amounts owing, therefore remain your sole responsibility.
- In the space provided below, kindly furnish a short summary of your request.
- Please attach the following mandatory supporting documents:
  - Latest proof of income
  - 3 months stamped bank statements (most recent)
  - Letter of motivation from treating healthcare provider
  - Copy of respective claim

  Any other supporting documents for your request e.g. scan reports, blood tests and at least 3 quotations from different service providers etc.

BASIS FOR YOUR REQUEST: Financial Hardship: ☐ Exceptional Circumstances: ☐ Both: ☐

Short Summary of your request:

SECTION A — MEMBERSHIP DETAILS

Membership Number:

Option:

PRINCIPAL (MAIN) MEMBER DETAILS

Initials and Surname:

ID/Passport Number:

BENEFICIARY/PATIENT DETAILS

Initials and Surname:

ID/Passport Number:

Date Joined: D D M M Y Y Y Y Benefit Date: D D M M Y Y Y Y

Dependant Information:	Name & Surname:	Age:
Dependant Information:	Name & Surname:	Age:
Dependant Information:	Name & Surname:	Age:
Dependant Information:	Name & Surname:	Age:

Postal Address:

Postal Code:

Residential Address:

Postal Code:

Email Address:

Telephone Number (W): C O D E

Telephone Number (H): C O D E

Cell Number:

SECTION B MEDICAL REPORT (to be completed by a registered medical service provider)

How long have you been treating the patient? Y Y M M

MEDICAL HISTORY (Past Examinations/Diagnosis/Severity/Prognosis/Functional Status)

Patient's Current Occupational Status:

TREATMENT PLAN & MEDICATION REQUIRED

HABITAT STATUS

Alcohol: Type Quantity

If Yes, indicate usage pattern: Daily Weekly

Smoker: Y N

If Yes, indicate usage pattern:

Started smoking: D D M M Y Y Y Y

Ended smoking: D D M M Y Y Y Y

Body Mass Index (BMI) Weight (kg): Height (m):

ARE THERE ANY DIETARY OR LIFESTYLE ADJUSTMENTS NEEDED?

DOCTOR'S ASSESSMENT OF WHY THIS CASE SHOULD BE REGARDED AS AN EXCEPTIONAL MEDICAL CIRCUMSTANCE THAT COULD NOT BE MANAGED WITHIN THE ALLOCATED BENEFITS

Doctor Name:																					
Practice Number:																					
Date:	D	D	M	M	Y	Y	Y	Y													

Signature: ______________________________

SECTION C — FINANCIAL REPORT (COMPLETION IS COMPULSORY) (to be completed by member)

MONTHLY EXPENDITURE

	Member	Spouse
Bond/Rent:	R	R
Municipal Rates & Taxes:	R	R
Electricity & Water:	R	R
Telephone (Totals of all Types):	R	R
Hire Purchase Payments – Specify:	R	R
A):	R	R
B):	R	R
C):	R	R
Insurance Premiums:	R	R
Transport:	R	R
Domestic & Garden Help:	R	R
Groceries:	R	R
Clothing:	R	R
Other:	R	R
Total Expenditure:	R	R

	Member	Spouse	Total
Gross Salary:	R	R	R
Gross Pension:	R	R	R
Other Income:	R	R	R
Total Income:	R		
Total Deductions:	R		
Total Net Income:	R		
Net Cash Surplus/Deficit:	R		

STATEMENT OF ASSETS

ASSETS	VALUE	LIABILITIES	VALUE
Residential Property Owned:	R	MORTGAGE BOND	R
Other Properties Owned:	R	MORTGAGE BOND	R
Owned:	R	MORTGAGE BOND	R
Owned:	R	MORTGAGE BOND	R
Shares & Investments:	R	BANK/OVERDRAFT	
Debtors & Loans:	R		
Other Significant Assets	R		
Total	R	TOTAL	R

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

Signature: ____ Date: D D M M Y Y Y Y

SECTION D — EMPLOYER / PENSION FUND INFORMATION

(to be completed by employer or pension fund - only if request is based on financial hardship)

Should the pension/investment administrator not be available, a copy of the applicant's latest pension slip and a letter or affidavit from the pension/investment administrator must be provided.

Name of Company:

We confirm that ____________ Is/was an employee of our company, and

Received a gross salary/pension of R: ____________ per month.

Length of service with the company: Y Y M M

RECOMMENDATION BY EMPLOYER/PENSION FUND

Contact Person:

Designation:

Email Address:

Telephone Number (W): C O D E

Cell Number:

SECTION D — OFFICE USE ONLY FINANCIAL REPORT

Previous Medical Scheme:

Option:

Does the member owe any moneys to the Scheme? Y N

If yes, specify amount:

Previous Ex Gratia granted Y N

TOTAL