

## Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

## Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## What is an ex gratia payment?

Ex gratia payment is a discretionary consideration by Discovery Health Medical Scheme that does not set a precedent, where the Scheme believes that an exceptional situation exists which warrants funding. An ex gratia payment is not a benefit defined within the Scheme Rules and should not be used to replace or supplement the existing benefits.

## Purpose of the form

We consider an ex gratia application in cases where a member incurs exceptional medical expenses not covered by the benefits available or the rules of the Scheme and, as a consequence the member has, or is likely to experience financial hardship. We review all the cases on individual merit and on a case-by-case basis.

Discovery Health Medical Scheme reviews the exceptional clinical circumstances and extreme financial hardship of each individual application, while considering fairness to the overall membership. As ex gratia payments are discretionary, the decisions made will not set a precedent, determine future benefits or affect Discovery Health Medical Scheme's rights in any way. The Scheme's decisions are final and cannot be disputed or appealed.

## How do I apply for an ex gratia payment?

We will only consider complete applications.

We need the following documents to consider an ex gratia application:

- The completed ex gratia application form
- The main member and spouse's most recent salary slip or pension advice and three months' current bank statements. You must give us the details even if your spouse is not a member of Discovery Health Medical Scheme. If the spouse or main member is recently unemployed, in the last 12 months, we require the UIF certificate and three months' current bank statements. If the spouse or main member is unemployed for longer than 12 months or has never been employed we will only require three months' current bank statements.
- All relevant and current clinical information from the treating doctor or healthcare practitioner, for example a clinical motivation
- All relevant and current supporting clinical information, for example radiology and pathology reports
- Detailed quotes on the treatment requested. If the treatment has happened already, send us the proof of payment relevant to the claims.

## What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- The main applicant must physically sign all relevant sections – you cannot sign it digitally. The main applicant must sign and date any changes.
- You can submit this form on [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

### 1. Main member's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First names (according to identity document)	<input type="text"/>		
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	<input type="text"/>
ID of passport number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>		
Telephone (W)	<input type="text"/>	Cellphone	<input type="text"/>
Email	<input type="text"/>		
How many dependants do you have who are not on your medical scheme membership?	<input type="text"/>		

Do you have other policies such as health insurance including gap cover, critical illness/dread disease cover, a hospital cash plan etc. ? Yes  No

If "Yes", please complete the below:

Name of plan  Effective date  -  -   
Type of gap cover

Your employment type:

Permanent  On contract  Commission-based  Retired  Unemployed  Self employed

## 2. Patient details

First names (according to identity document)   
Surname   
Age  Relationship to main member

## 3. How we can communicate the decision to you

Telephone  Email  Post

Details of above

## 4. Income and expenditure statement (member to complete)

### 4.1. Monthly income and expenses

#### Income

Source	Member	Spouse	Total
Gross salary	R	R	R
Other income (like investments, trust fund income, interest, spousal support, rental income, medical scheme subsidy)	R	R	R
<b>Total income</b>	<b>R</b>	<b>R</b>	<b>R</b>
Total deductions (PAYE; UIF, skills levy)	R	R	R
<b>Net income</b>	<b>R</b>	<b>R</b>	<b>R</b>

#### Expenditure

Bond/rent	R
Retirement annuity	R
Medical scheme contributions	R
Other medical expenses	R
Municipal rates and taxes (attach latest statement)	R
Electricity and water	R
Telephone and Internet	R
Hire purchase payments (like car instalments). Please specify:	
1.	R
2.	R
3.	R



## 5. Ex gratia request

5.1. What are you requesting? (Please be specific and clear)


5.2. Diagnosis and relevant ICD-10 diagnosis codes


Date of diagnosis    

D	D
---	---

 - 

M	M
---	---

 - 

Y	Y	Y	Y
---	---	---	---

5.3. Costs involved (rand value)

Please attach quotations, invoices or treatment plans or all of these. We do not accept approximate figures.


5.4. Reason for ex gratia request

Please explain why you are applying for an ex gratia consideration.


I, 

--	--

 on 

D	D
---	---

 - 

M	M
---	---

 - 

Y	Y	Y	Y
---	---	---	---

(please print your name and surname) agree that by applying for ex gratia, I accept that:

- The committee decides according to the merits of each individual case. Their decision may not be used to justify a similar decision in future.
- The committee does not have to approve the request, and there is no appeal process if my application is declined.
- Any decision the committee makes is based on the information I have supplied.

Signed at (town or city) 

--	--

 on 

D	D
---	---

 - 

M	M
---	---

 - 

Y	Y	Y	Y
---	---	---	---

Signature of main applicant

--



**Please only sign if information is true, complete and correct.**