APPLICATION FOR EX GRATIA ASSISTANCE

PLEASE COMPLETE FORM IN BLOCK LETTERS

- Ex gratia payments may only be made by the Ex Gratia Committee at its absolute discretion, provided it is satisfied that extreme financial hardship would be imposed upon the member. Ex gratia payments may not be considered in advance of any excess in benefit arising.
- **This application will not be submitted to the Committee if any sections are incomplete (unless stated as 'not applicable').**
- Return this completed form to the Scheme by email, post or fax marked for the attention of the Ex Gratia Department.

1. REASONS AND MOTIVATION FOR EX GRATIA ASSISTANCE

Basis for this request: ☐ Financial hardship ☐ Exceptional circumstances ☐ Both

Please provide a short summary of your request and details of the benefits exceeded. Attach supporting documentation and copies of claims, where necessary.

2. PERSONAL PARTICULARS

PRINCIPAL MEMBER

Membership number			
Full name and surname			
Join date of PG Group Medical Scheme	DD/MM/YYYY		
Join date of PG Group (employment)	DD/MM/YYYY		
Contact numbers		Home	Work
		Cell phone	
Postal address			
		Postal code	
Email address			

2. PERSONAL PARTICULARS (CONTINUED)

DEPENDANTS

Please provide the details of your dependants who are registered on the Scheme.

Dependant code		Full name and surname		Age	
Dependant code		Full name and surname		Age	
Dependant code		Full name and surname		Age	
Dependant code		Full name and surname		Age	

DETAILS OF PERSON IN RESPECT OF WHOM THE APPLICATION IS MADE

Dependant code	
Full name and surname	
Contact number	
Email address	

3. CLINICAL REPORT

This section must be completed by the attending medical practitioner.

MEDICAL HISTORY

Diagnoses and ICD-10 codes

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

Please provide details of past examination, diagnosis, severity, prognosis and functional status of the patient.

Current employment status

3. CLINICAL REPORT

MEDICAL HISTORY (CONTINUED)

Treatment plan and medication required

Gender

☐ Male ☐ Female ☐ Other

Body mass index (BMI)

Weight ____ kg Height ____ cm

Alcohol consumption

e.g. 2 glasses of red wine per day

	quantity e.g. 2		*unit e.g. glass, can*	of	*alcohol type e.g. red wine, beer*	per	*time period e.g. day/week/month*
	quantity e.g. 2		*unit e.g. glass, can*	of	*alcohol type e.g. red wine, beer*	per	*time period e.g. day/week/month*
	quantity e.g. 2		*unit e.g. glass, can*	of	*alcohol type e.g. red wine, beer*	per	*time period e.g. day/week/month*

Has the patient ever received medical advice to reduce or discontinue consumption of alcohol? ☐ Yes ☐ No

Smoking status

Past smoker ☐ Yes ☐ No

Started DD/MM/YYYY

Stopped DD/MM/YYYY

Current smoker ☐ Yes ☐ No

Average number of cigarettes smoked per day ____

Please specify other smoking habits e.g. vape, cannabis, hookah, etc.

Has the patient ever received medical advice to reduce or discontinue smoking?

☐ Yes ☐ No

Are any other lifestyle or dietary adjustments required?

3. CLINICAL REPORT

MEDICAL HISTORY (CONTINUED)

Have there been any problems with non- or poor compliance relating to medical advice or treatment given to this patient?

Medical practitioner's assessment of why this case should be regarded as an exceptional medical circumstance that warrants ex gratia assistance and that could not be managed within the allocated Scheme benefits.

Full name and surname of attending medical practitioner	
Practice number	
Speciality/discipline	
Contact number	
Email address	
Signature	**Date** DD/MM/YYYY

4. FINANCIAL INFORMATION

This section must be completed by the principal member. If there are other occupants who contribute to your household income, please specify.

HOUSEHOLD INCOME

	Principal member	Spouse/life partner	Other
Gross salary	R	R	R
Gross pension	R	R	R
Other income	R	R	R
Total gross income	R	R	R
Total deductions (e.g. UIF, PAYE etc.)	R	R	R
TOTAL HOUSEHOLD NET INCOME (Total gross income less Total deductions)	**R**	**R**	**R**

HOUSEHOLD EXPENSES

Please provide details of your household expenses, including that of the main member, spouse/life partner or other occupants. If there are other occupants who contribute to your household expenses, please specify. If you already have a documented household budget, you may include it in support of this application.

Monthly expenses	Principal member	Spouse/life partner	Other
Bond (home loan)	R	R	R
Rent	R	R	R
Municipal rates and taxes	R	R	R
Water and electricity	R	R	R
Telephone/Cell phone	R	R	R
Internet service provider	R	R	R
Medical scheme contribution	R	R	R
Education fees (school, tertiary, university)	R	R	R
Vehicle repayments	R	R	R
Household insurance	R	R	R
Car insurance	R	R	R
Funeral cover	R	R	R
Life insurance	R	R	R
Transport and petrol	R	R	R
Groceries	R	R	R
Domestic and garden help	R	R	R
Clothing	R	R	R
Other (please specify below):			
	R	R	R
	R	R	R
	R	R	R
	R	R	R
	R	R	R
TOTALS	**R**	**R**	**R**

4. FINANCIAL INFORMATION (CONTINUED)

STATEMENT OF ASSETS

Assets	Value
Residential property owned	R
Other properties*	R
Vehicles and furniture	R
Shares and investments	R
Cash in bank	R
Other significant assets	R
TOTALS	**R**

Liabilities	Value
Mortgage bonds	R
Bank overdraft	R
Debt/loans	R
Creditors	R
TOTALS	**R**

*Please provide details of your other properties, i.e. second home, vacation home or rental property.

FINANCIAL STANDING

Total household net income

R

Total expenditure

R

Total balance (Income less expenses)

R

5. MEMBER DECLARATION

I hereby authorise and give consent to the Scheme, the Administrator and/or its duly authorised service providers to collect, store, collate, process, share and further process my personal information, including health information, which relates to any aspect of my Scheme membership and that of my dependants.

I understand that any false information on this application form will render my application null and void, and that PG Group Medical Scheme will be entitled to claim from myself any amounts that might have been paid in respect of this application and further at the Scheme's discretion, may result in the termination of my medical scheme membership.

I, the undersigned, hereby warrant that the information as supplied herein is both true and correct.

Signature of principal member

Date DD/MM/YYYY

01/2025

DISCLAIMER:
PG Group Medical Scheme reserves the right to list members who, in the opinion of the Scheme's Administrator, Momentum Health (Pty) Ltd Fraud and Ethics Committee, have behaved unethically towards the Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against the Scheme, on the TransUnion Credit Bureau. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders' (BHF) Forensic Management Unit.

PG GROUP MEDICAL SCHEME

Administered by Momentum Health (Pty) Ltd

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