

EX-GRATIA APPLICATION FORM - Application for Additional Benefits

IMPORTANT - PLEASE NOTE

- Ex-Gratia payments may only be made by the Committee at its absolute discretion provided it is satisfied that extreme hardship would otherwise 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 should any section be incomplete.
- This application form should be forwarded to the **NAMPAK SA MEDICAL SCHEME, Ex-Gratia Department, P.O.Box 2338, Durban 4001**
- In the space provided kindly furnish details of the benefit exceeded, and to whom payment must be made, should the application be successful.

Basis for this request:

Financial Hardship

Exceptional Circumstances

Both

Name of Member:

Date Commenced Membership with the Scheme:

Date Commenced Employment with the Nampak group:

Postal Address:

Membership No:

Name of Dependents & Ages:

NAME AGE

NAME AGE

NAME AGE

NAME AGE

DETAILS OF PERSON IN RESPECT OF WHOM THE APPLICATION IS MADE:

Name:

Contact Name:

Contact Telephone No: **Work** **Home:**

**CONFIDENTIAL
MEDICAL REPORT TO BE COMPLETED BY PRACTITIONER**

Should you wish to return this CONFIDENTIALLY to the Scheme, please fax to **031 580 0470**

Medical History
<i>How long have you been involved in the medical care of this patient?</i>
Past Examination/Diagnosis/Severity/Prognosis/Functional Status
Present Occupation Status:
Treatment Plan & Medication Required:
Habit Status
What kind and quantity of alcoholic liquor does the patient consume? Per day: Per week:
Smoking Status: Past smoker: Yes/No Started Stopped Ave per day Present Smoker: Yes/No Has the patient ever received medical advice to reduce or discontinue smoking?

CONFIDENTIAL
To be completed by member.

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	Member	Spouse (Including Common Law)	Total
Gross Salary			
Pension			
Other Income			
Total			

<i>Less Expenses</i>			
<i>Total Net Income</i>			

I _____,
the undersigned, hereby warrant that the information as supplied herein is both true and correct. I understand that the rendering of any false information on this application form will render my application null and void and that the Society 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.

Signature

Date