

# Ex gratia application form



Administered by Discovery Health

## Contact details

Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • [www.yourremedi.co.za](http://www.yourremedi.co.za)

## Who we are

Remedi is the medical scheme, registration number 1430, which is registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as “we” “us” and “our” or as “the administrator”) is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Remedi.

## What is ex gratia?

Ex gratia is a discretionary grant and approved by the Remedi Medical Aid Scheme Board of Trustees or it's appointed sub-committee(s), where it is considered to warrant additional funding, per the discretion of the Board of Trustees or it's appointed sub-committee(s). Ex gratia is not a benefit defined within the Scheme benefit rules and is not allowed to be used to replace or supplement existing benefits.

## Ex gratia considerations?

The Scheme's Medical Advisory Committee reviews the exceptional clinical circumstances of each individual application, while considering fairness to the overall membership. As ex gratia is discretionary, the decisions made will not set a precedent, determine future benefits or affect Remedi Medical Aid Scheme's rights in any way. All the cases are reviewed on individual merit and on a case-by-case basis.

## How do I apply for ex gratia?

The application form and all attachments need to be signed by the member. Please complete the application form in full, attaching all the relevant information.

Fax the completed form and attachments to 011 539 2239 or email it to [exgratia@yourremedi.co.za](mailto:exgratia@yourremedi.co.za).

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

I accept that:

- The Committee's decision is made according to the merits of each individual case and may not be used to justify a similar decision in future.
- The Committee does not have to approve the request.
- Any decision the Committee makes is based on the information I have supplied.

Signed at (town or city)  on 

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Signature of main applicant

The main applicant must sign and date any changes

## 1. Main member's details

Title     Initials     Surname

First name(s) (as per identity document)

Membership number

Telephone (H)       (W)

Cellphone       Fax

Email address

## 2. Patient's details

Title     Initials     Surname

First name(s) (as per identity document)

Age   Relationship to main member

REMEGA001

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

Telephone  Fax  Email  Post

Details of above


### 4. Ex gratia request

4.1. What is being requested? (Please be specific and clear)


4.2. Costs involved (rand value)

- Please attach quotations or invoices or treatment plans or all of these.
- Approximate figures will not be accepted.


4.3. Reason for ex gratia request.

- Please explain why you are applying for an ex gratia consideration.
- Please attach all motivations, explanations and reasons. List all the documents you are submitting with your ex gratia application, for example doctor's report or x-rays or tests or scans.


The following supporting documentation will be required as a minimum requirement to review your application.

Please tick in the appropriate block to confirm documentation that has been enclosed

Additional clinical information from the treating doctor/practitioner

Account(s) (if applicable)

Quotes (if applicable)

Other information (specify)


### Office check

Member details  Request  Cost  Reason