

Application for ex gratia assistance

Membership number	<input type="text"/>	Employee number	<input type="text"/>
Main member surname	<input type="text"/>		
First name	<input type="text"/>	Initials	<input type="text"/>
Cell phone number	<input type="text"/>		
Work telephone number	<input type="text"/>	Fax number	<input type="text"/>
E-mail address	<input type="text"/>		
Postal address	<input type="text"/>		
	<input type="text"/>	Code	<input type="text"/>
Number of dependants	<input type="text"/>	Monthly income	<input type="text"/>
Name of person having treatment	<input type="text"/>		
Reason for application	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

(Please enclose medical practitioner's report.)

Details of assistance required	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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(Please attach copies of accounts.)

Are you participating in the Chronic Medication Programme?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any major medical policies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If YES, to what extent will it cover expenses?	<input type="text"/> <input type="text"/> <input type="text"/>
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I declare that these particulars are true and correct.

Signature of member

Date

Return address: Ex Gratia, PO Box 343, Westville 3630
Fax 031 267 0227 E-mail pnexgratia@pha.co.za