

## Application for special payments to be made from the Accumulated Savings Account

### Who are we

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

### How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full and signed.
3. Please email completed application to [service@engenmed.co.za](mailto:service@engenmed.co.za).

**When you sign this application, you confirm that the information provided is true and correct.**

### 1. Patient's details

|  |                      |                   |                      |
|--|----------------------|-------------------|----------------------|
| Title                                    | <input type="text"/> | Initials          | <input type="text"/> |
| Surname                                  | <input type="text"/> |                   |                      |
| First name(s) (as per identity document) | <input type="text"/> |                   |                      |
| ID or 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"/> |                   |                      |
| Relationship to main member              | <input type="text"/> |                   |                      |

### 2. Claim details

|                               |                      |                        |                      |
|-------------------------------|----------------------|------------------------|----------------------|
| Date of treatment             | <input type="text"/> |                        |                      |
| Name of supplier of treatment | <input type="text"/> |                        |                      |
| Practice number               | <input type="text"/> | Amount being claimed R | <input type="text"/> |
| Treatment description         | <input type="text"/> |                        |                      |

1. Please attach the original claim(s) to this application form.
2. If the payment of the attached claim(s) is approved, it will be paid from your Accumulated Savings Account during the next claims payment run.
3. There are certain criteria that you need to be aware of before you apply for a special payment from your Accumulated Savings Account:
  - The principal member must complete and sign this application form.
  - A valid account is needed to approve your special payment. The account must be attached to this application form. A special payment will not be approved on quotations, as you may only apply for a special payment for procedures or treatment already received – not for future expenses.
  - Special payments from your Accumulated Savings Account will only be considered for claims where the healthcare provider is appropriately registered with the Board of Healthcare Funders (BHF). This means the healthcare provider must have a valid BHF practice number.
  - If you have a waiting period, you will not be allowed to apply for a special payment from your Accumulated Savings Account.
  - Special payments from your Accumulated Savings Account are always subject to an approval process.
  - If approved, the special payment from your Accumulated Savings Account will be made to you, the member, and not directly to the provider, as you are responsible for ensuring payment of medical accounts.

4. The above decision is made on a discretionary basis. The Fund will not be held responsible for any consequences, (whether clinical or financial), that may result from the above-mentioned procedure. By having the procedure performed and accepting the “Accumulated Savings Account exception” funding decision, you indemnify the Fund against any claims for loss or damages related to this exceptional payment, that may for any reason be brought against the Fund.

Principal member signature

**Please do not sign an incomplete application form**

Date 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|