

## Chronic Illness Benefit application form

This application form is to apply for the Chronic Illness Benefit and is only valid for 2026

The latest version of the application form is available on [www.engenmed.co.za](http://www.engenmed.co.za). Alternatively you can phone 0800 001 615 or your doctor can phone 0860 44 55 66.

### Who we are

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. You (the member) must complete and sign Section 1 of this form.
3. Take the application form to your doctor to complete section 2, other relevant sections, sign section 8 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
4. Please email the completed application form and all supporting documents to [CIB\\_APP\\_FORMS@engenmed.co.za](mailto:CIB_APP_FORMS@engenmed.co.za) or post it to Engen Medical Benefit Fund, CIB Department, PO Box 652509, Benmore, 2010.

### 1. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<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"/>		

The outcome of this application will be communicated to you by email.

I give consent to Discovery Health (Pty) Ltd and Engen Medical Benefit Fund to use the above communication channel for all future communication.

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

Patient's signature	<input type="text"/>	Date	<input type="text"/>
(if patient is a minor, main member to sign)			

### 2. Doctor's details

Name and surname	<input type="text"/>		
Practice number	<input type="text"/>	Speciality	<input type="text"/>
Telephone	<input type="text"/>		
Email	<input type="text"/>		

The outcome of this application will be communicated to you by email.

### **Member's acceptance and permission**

I give permission for my healthcare provider to provide EMBF and the Administrator with my diagnosis and other relevant clinical information required to review my application. I agree to give permission for you to collect and record information about my condition and treatment, this will also be used to develop registries. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

- 2.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by EMBF.
- 2.2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit.
- 2.3. By registering for the Chronic Illness Benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- 2.4. Funding for medicine from the Chronic Illness Benefit (CIB) will only be effective from when EMBF receives an application form that is completed in full. I can refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which I am applying.
- 2.5. A new Chronic Illness Benefit application form needs to be completed when applying for a new chronic condition.
- 2.6. If I am approved on the benefit, I need to let EMBF know when my treating doctor changes my treatment plan so my chronic authorisation/s can be updated. I can do this by emailing the new prescription to the email provided or asking my doctor or pharmacist to do this for me. Alternatively, my doctor can log onto HealthID to make the changes, provided that I have given consent. If I do not let EMBF know about changes to my treatment plan, my claims may not be paid from the correct benefit.
- 2.7. To make sure that my claims are paid from the correct benefit, the claims from my doctors must be submitted with the relevant ICD-10 diagnosis code(s). I must ask my doctor to include my ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer me to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that my claims are paid from the correct benefit.

### **Consent for processing my personal information**

I give EMBF and the Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Fund and the Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.

### **Consent withdrawal for your Chronic Illness Benefit (CIB)**

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable chronic illness benefits. Claims which would usually be funded from the chronic illness benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan.

Should you wish to continue with the consent withdrawal process, then please email [CIB\\_APP\\_FORMS@engenmed.co.za](mailto:CIB_APP_FORMS@engenmed.co.za).

### 3. The Chronic Disease List (CDL) conditions covered on EMBF

EMBF covers the following Chronic Disease List (CDL) conditions in line with legislation. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the [website](#) for more information on what is covered on the benefit and how it is covered.

Chronic disease list condition	Benefit entry criteria requirement
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician
Asthma	None
Bipolar mood disorder	Application form must be completed by a psychiatrist
Bronchiectasis	1. Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician OR 2. Application form completed by a general practitioner - with clinical symptoms and x-ray or CT features in keeping with bronchiectasis
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report that includes the FEV1/FVC post bronchodilator use 2. Please provide additional information when applying for oxygen including: 2.1. arterial blood gas report off oxygen therapy 2.2. number of hours of oxygen use per day
Chronic renal disease	1. Application form must be completed by anephrologist, specialist physician or general practitioner 2. Please attach a supporting laboratory report reflecting creatinine clearance or urine albumin creatinine ratio (uACR). General Practitioners - Please attach all laboratory reports from the past six months
Coronary artery disease	None
Crohn's disease	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist or specialist physician
Diabetes type 1	None
Diabetes type 2	Section 7 of this application form must be completed by the doctor. Please attach the diagnosing laboratory report
Dysrhythmia	None
Epilepsy	1. Application form for newly diagnosed patients must be completed by a neurologist, paediatrician (in the case of a child) or specialist physician OR 2. Application form completed by a general practitioner - with a confirmatory EEG
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	Please attach the diagnosing laboratory report reflecting factor VIII or IX levels
HIV and AIDS (antiretroviral therapy)	Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare programme, please call 0800 001 615
Hyperlipidaemia	Section 5 of this application form must be completed by the doctor. Please attach the diagnosing laboratory report
Hypertension	Application form must be completed by a specialist physician for patients <30 years of age
Hypothyroidism	Section 6 of this application form must be completed by the doctor. Please attach the diagnosing laboratory report
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon including: 2.1. Relapsing – remitting history 2.2. All MRI reports 2.3. Extended disability status score (EDSS)
Parkinson's disease	Application form must be completed by a neurologist or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, paediatrician (in the case of a child) or specialist physician
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician
Ulcerative colitis	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon

#### 4. The Additional Disease List (ADL) conditions covered on EMBF

Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your ADL condition(s) offers cover for medicine for the management of your condition(s). Please refer to the [website](#) for more information on how medicine is covered on the benefit.

Additional disease list condition	Benefit entry criteria requirements
Allergic rhinitis	None
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Arthritis, unspecified	None
Attention deficit hyperactivity disorder	Application form must be completed by a specialist (psychiatrist, neurologist or paediatrician)
Chronic urticaria	Application must be completed by a dermatologist
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Depression	Applications for first line therapy will be accepted from GPs for six (6) months only. Application from a psychiatrist will be required for further cover. Application form must be completed by a psychiatrist for patients < 18years of age.
Eczema	Application must be completed by a dermatologist
Gastro-oesophageal reflux disease (GORD)	Application form must be completed by a gastroenterologist, general surgeon or paediatrician (in the case of a child)
Gout	Uric acid levels must be provided, prophylaxis therapy only
Meniere's disease	None
Migraine	Application must be completed by a specialist physician
Motor neurone disease	Application form must be completed by a neurologist
Myasthenia gravis	None
Narcolepsy	Application form must be completed by a specialist physician
Osteoporosis	1. All applications must be accompanied by a diagnosing DEXA bone mineral density scan (BMD) report 2. Application form must be completed by an endocrinologist, gynaecologist, rheumatologist, specialist physician or oncologist for patients < 50 years of age 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child)
Psoriasis	Application form must be completed by a dermatologist
Psoriatic arthritis	Application form must be completed by a rheumatologist or specialist physician
Pulmonary fibrosis	Application form must be completed by a paediatrician (in the case of a child) or pulmonologist
Scleroderma and other collagen vascular diseases	None
Trigeminal neuralgia	Application form must be completed by an anaesthesiologist, neurologist, otorhinolaryngologist (ENT) or specialist physician
Urinary incontinence	None
Zollinger Ellison syndrome	None

#### 5. Application for hyperlipidaemia (to be completed by Doctor)

If the patient meets the requirements listed in either A, B, C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis.

##### A. Primary Prevention

Please attach the diagnosing lipogram

Please supply the patient's current blood pressure reading  /  mmHg

Is the patient a smoker or has the patient ever been a smoker?

Yes  No

Please use the Framingham 10-year Risk Assessment Chart as per the 2018 South African Dyslipidaemia Guidelines to determine the absolute 10-year risk of a coronary event and indicate:

Does the patient have a risk of 20% or greater

Yes

OR

Is the risk 30% or greater when extrapolated to age 60

Yes

**B. Familial hyperlipidaemia**

Please attach the diagnosing lipogram

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist?

Yes

Please attach supporting documentation.

**OR**

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist?

Yes

Please attach supporting documentation.

**C. Secondary prevention**

Please indicate what your patient has:

Diabetes type 2

Stroke

TIA

Coronary artery disease

Chronic kidney disease. Please supply the diagnosing laboratory report reflecting creatinine clearance

Peripheral arterial disease. Please supply the doppler ultrasound or angiogram

Diabetes type 1 with microalbuminuria or proteinuria

Any vasculitides where there is associated renal disease. Please supply the diagnosing laboratory report reflecting creatinine clearance

Solid organ transplant. Please supply the relevant clinical information in Section D

**D. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia.**

**E. Was the patient diagnosed with hyperlipidaemia more than five (5) years ago and the laboratory results are not available?**

Yes

**6. Application for hypothyroidism (to be completed by Doctor)**

**If the patient meets the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.**

**A. Thyroidectomy:** Please indicate whether your patient has had a thyroidectomy

Yes

**B. Radioactive iodine:** Please indicate whether your patient has been treated with radioactive iodine

Yes

**C. Hashimoto's thyroiditis:** Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis

Yes

**D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels**

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level

Yes

**OR**

A raised TSH but normal T4 level and higher than normal thyroid antibodies

Yes

**OR**

A raised TSH level of greater than or equal to 10 mIU/l on two (2) or more occasions at least three (3) months apart in a patient with a normal T4 level

Yes

**E. Was the patient diagnosed with hypothyroidism more than five (5) years ago and the laboratory results are not available?**

Yes



**Notes to doctor**

- 8.1. To assist us in paying claims from the correct benefits, please ensure that the date on which the condition was first diagnosed is stipulated in the table above.
- 8.2. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.
- 8.3. Please include the ICD-10 diagnosis code(s) when referring your patient to pathologists and radiologists. This will enable pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.
- 8.4. We will approve funding for generic medicine, where available, unless you have indicated otherwise.
- 8.5. Please submit all the requested supporting documents with this application to prevent delays in the review process.
- 8.6. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by emailing the new prescription to us or by logging onto HealthID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature

Date 

D	D	M	M	Y	Y	Y	Y
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