

Application for additional benefits

Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') administers the Scheme. Discovery Health (Pty) Ltd (registration number 1997/013480/07) is a registered financial services provider.

What is an additional benefit?

It is a discretionary consideration, which is only made if the Scheme believes an exceptional situation exists that warrants payment in excess of the stated benefits. An additional benefit is not a benefit that the Scheme has to offer, nor is it guaranteed that your request for additional benefits will be approved.

How are additional benefits decisions made?

The Scheme reviews the additional benefits application, which should be completed by the member asking for consideration. Only applications with complete information can be reviewed. It is your responsibility to make sure that all the information we ask for is on the application form, and attached to it.

What happens if my application is declined?

As additional benefits are discretionary, the Scheme may decline any application without affecting its own rights in any way.

The Scheme's decisions are final and can't be disputed or appealed against. Any additional benefits allocation is not meant to replace or supplement the available registered benefits.

How do you apply for additional benefits?

The application form and all attachments need to be completed in full, attaching all the relevant information. Email the completed form and attachments to EX_GRATIA@lahealthms.co.za

I,

(please print your name and surname) agree that by applying for additional benefits, I accept that:

- The Scheme's decision is based on the merits of this case, and may not be used to justify a similar decision in future.
- The Scheme does not have to approve the request, and there is no appeal process if my application is declined.
- Any decision made by the Scheme, is based on the information I have supplied.

Signed at (town or city) on

Signature of applicant

The applicant must sign and date any changes.

1. Main member'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"/>		

2. Beneficiary who has/will be incurring the costs

Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Age	<input type="text"/>	<input type="text"/>	Relationship to main member <input type="text"/>

3. How must we communicate the decision

Telephone	<input type="checkbox"/>	Email	<input type="checkbox"/>
Details of above			
Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	<input type="text"/>		

4. Additional benefits request

4.1 What is being requested?

(Please be specific and clear)

<input type="text"/>
<input type="text"/>
<input type="text"/>

4.2 Costs involved (rand value)

- Please attach quotations, invoices or treatment plans for each of the requests.
- Approximate figures will not be considered.

<input type="text"/>
<input type="text"/>
<input type="text"/>

4.3 Reason for additional benefits request

- Please explain why you are applying for an additional benefits consideration.
- Please attach all motivations, explanations and reasons. List all the documents you are submitting with your additional benefits application, for example doctor's reports, X-rays, tests or scans done.

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

The following supporting documents need to be provided as a minimum requirement to review your application.

Please tick in the appropriate block to confirm documents have been enclosed

Additional clinical information from treating doctor	<input type="checkbox"/>
Account(s) (if applicable)	<input type="checkbox"/>
Quotes (if applicable)	<input type="checkbox"/>
Other information (specify)	<input type="checkbox"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Office check

Member details	<input type="checkbox"/>	Request	<input type="checkbox"/>
Cost	<input type="checkbox"/>	Reason	<input type="checkbox"/>