



medical scheme

# Application for Prescribed Minimum Benefits

- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark square clearly with a X

For Office use only:  
Member number:

**Enquiries:**  
Tel: 0860 787 372  
Fax: 0860 288 363  
Selfmed Medical Scheme  
PO Box 5543  
Tygervalley 7536

Reg. No: 1446 FSP No: 15494

This form is to be completed by the applicant.

## A Member details

Surname	<input type="text"/>	Initials	<input type="text"/>
Full names	<input type="text"/>	Title	<input type="text"/>
Selfmed Option name	<input type="text"/>		
Membership Number	<input type="text"/>		

## B Patient Details

Please submit a copy of the first page of your identity document.

Identity number	<input type="text"/>	Date of birth	<input type="text"/>
Beneficiary code	<input type="text"/>		
Surname	<input type="text"/>	Initials	<input type="text"/>
Full names	<input type="text"/>	Title	<input type="text"/>
Physical address	<input type="text"/>		
Postal address	<input type="text"/>		
		Postal code	<input type="text"/>
		Postal code	<input type="text"/>
Telephone (h)	<input type="text"/>	Telephone (w)	<input type="text"/>
Cellphone	<input type="text"/>		
Fax	<input type="text"/>		
E-mail address	<input type="text"/>		
Preferred method of communication	Telephone <input type="checkbox"/>	E-mail <input type="checkbox"/>	SMS <input type="checkbox"/> Ordinary mail <input type="checkbox"/>



**By completing this application form, you are applying for benefits to manage your PMB condition in accordance with legislation and the Selfmed Scheme rules. This is, however NOT an application form for chronic medicine benefits. To obtain chronic medicine authorisation, please request your treating physician to phone Selfmed on 0860 247 288.**

I/we understand that all personal and clinical information supplied will be kept confidential. The information will be used to determine the patient's eligibility for additional benefits (and the reimbursement thereof) in order to manage their condition.

I/we hereby authorise any medical practitioner and/or medical facility in possession of any medical information with regards to my medical condition to provide the managed healthcare provider of Selfmed Medical Scheme from time to time, with such information as they may require.

\_\_\_\_\_  
Signature of member

\_\_\_\_\_  
Signature of patient

(not required if patient is a minor)

Date: