



# CHRONIC BENEFIT

## APPLICATION FORM

BROKER NAME :	INCEPTION DATE REQUIRED:
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### PERSONAL DETAILS

Surname:	Title:	Male	Female	
First Names:				
Postal Address:				
	Postal Code:			
Residential Address:				
	Postal Code:			
Telephone Number (home):	Telephone Number (work):			
Cellular Number:	Fax Number or e-mail:			
Occupation:	Married	Divorced	Single	Widowed
Date of Birth:	Citizenship / Nationality:			
Identity Number:	Signature:			

Applicant details: (if the application benefit is for a dependant)				
Surname:			Title:	
First Names:			Date of Birth:	
Occupation:	Male	Female		

### CHRONIC MEDICATION APPLICATION DETAILS (Tick the appropriate condition per category)

Category	Condition Covered	Monthly Benefit	Tick
A	Congestive Heart Disease	R115	
	Asthma	R115	
	Diabetes - Type 2	R115	
	Bronchiectasis	R115	
	Glaucoma	R115	
	Chronic Obstructive Respiratory Disease	R115	
	Atopic Eczema	R115	
	Osteoarthritis	R115	
	Hormonal Supplement (post menopausal)	R115	
	Psoriasis	R115	
	Benign Prostatic Hypertrophy	R115	
B	Hyperthyroidism	R140	
	Reynauds Disease	R140	
C	Ischaemic Heart Disease	R170	
	Osteoporosis	R170	
	Peripheral Vascular Disease	R170	
	Chronic Renal Failure	R170	
D	Hypertension	R170	
	Cerebrovascular Disease	R230	
	Hyperlipidaemia	R230	
	Rheumatoid Arthritis	R230	
	Epilepsy	R230	
	Gastric Ulcer	R230	
E	Multiple Sclerosis	R285	
	Cirrhosis	R285	
	Arrhythmia	R285	
F	Diabetes - Insipidus & Type 1	R565	
	Cancer	R565	
	Parkinson's Disease	R565	

Practitioner:	Practice Number:
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