

Contact details

Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.co.za

Request for additional cover for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2025

Please complete this form if you want to request additional cover for your approved Chronic Disease List (CDL) condition.

Who we are

The BMW Employees Medical Aid Society (referred to as 'Society'), registration number 1526, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Society.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Email the completed and signed form to **CIB_APP_FORMS@bemas.co.za**.
3. To avoid administrative delays, please ensure this form is completed in full by you and your doctor.

1. About the patient (member to complete if patient is a minor)

| | | | |
|----------------------|----------------------|-------------------|----------------------|
| Name and Surname | <input type="text"/> | | |
| ID / Passport number | <input type="text"/> | Membership number | <input type="text"/> |
| Telephone | <input type="text"/> | Cellphone | <input type="text"/> |
| Email Address | <input type="text"/> | | |

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

I give consent to BMW Employees Medical Aid Society and Discovery Health (Pty) Ltd to use the above communication channel for all future communication.

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

2. Request for additional consultations and procedures (Doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

| Condition | Consultation or procedure code | Number of consultations or procedures required per year | Supporting information for the request |
|-----------|--------------------------------|---|--|
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3. Request for cover in full for non-formulary medicine (Doctor to complete)

Please complete the table below where non-formulary medicine is prescribed for the treatment of CDL conditions and the request is for cover without co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

| Medicine name and strength | Quantity | Supporting information for the request |
|----------------------------|----------|--|
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Previous medicine history

| Medicine name and strength | Date treatment with this medicine was initiated | How long did the patient use the medicine for? | Details of treatment failure or adverse drug reactions |
|----------------------------|---|--|--|
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4. Doctor's details (Doctor to complete)

Name and surname

Practice number Speciality

Telephone

Email

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

Doctor's signature

Date