



Registration for Prescribed Minimum Benefit (PMB) Chronic Disease Conditions

Control Number

Completed Forms MUST be returned by Post to the above address or be Faxed to 012-674-8032

1: PRINCIPAL MEMBER / DEPENDANT / PATIENT DETAILS (Complete One Form per Applicant)

Surname:	Medical Plan and Option:
First Names:	Membership Number:
Postal Address:	Principal Member Date of Birth:
	Dependant / Patient Surname:
Postal Code:	Dependant / Patient First Names:
Telephone Number: Home ()	Dependant / Patient Code:
Telephone Number: Work ()	Dependant / Patient Date of Birth:
E-mail Address:	

2: DIAGNOSED PMB CHRONIC DISEASE CONDITION/S* (Tick the Applicant's diagnosed disease condition/s)
* Additional documentation may be required for pre-authorization.

- | | |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1 <input type="checkbox"/> Addison's disease | 13 <input type="checkbox"/> Epilepsy |
| 2 <input type="checkbox"/> Asthma | 14 <input type="checkbox"/> Glaucoma |
| 3 <input type="checkbox"/> Bronchiectasis | 15 <input type="checkbox"/> Haemophilia |
| 4 <input type="checkbox"/> Cardiac Failure | 16 <input type="checkbox"/> Hyperlipidaemia (High Cholesterol) |
| 5 <input type="checkbox"/> Cardiomyopathy | 17 <input type="checkbox"/> Hypertension (High Blood Pressure) |
| 6 <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (e.g. Emphysema) | 18 <input type="checkbox"/> Hypothyroidism (Inactive Thyroid Gland) |
| 7 <input type="checkbox"/> Chronic Kidney Disease | 19 <input type="checkbox"/> Multiple Sclerosis |
| 8 <input type="checkbox"/> Coronary Artery Disease | 20 <input type="checkbox"/> Parkinson's Disease |
| 9 <input type="checkbox"/> Crohn's disease | 21 <input type="checkbox"/> Rheumatoid Arthritis |
| 10 <input type="checkbox"/> Diabetes Insipidus | 22 <input type="checkbox"/> Schizophrenia |
| 11 <input type="checkbox"/> Diabetes Mellitus | 23 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) |
| 12 <input type="checkbox"/> Dysrhythmia (Irregular Heartbeat) | 24 <input type="checkbox"/> Ulcerative Colitis |

3: DECLARATION

I declare and understand that my application shall be null and void if any information supplied by me should be false or incomplete, in which case I will repay all monies paid to me (or on my behalf) by the Scheme for benefits received in the treatment of any of the disease conditions ticked above.

I give my irrevocable consent to any medical doctor, person or organization who may possess, or come into possession of any information to disclose this information to the Scheme, if such information is required for the management of my health or the health of my dependants.

Signatures:

Principal Member

Patient

Signed at on this day of 200

NOTE: Failure to register your diagnosed disease condition will result in your treatment regime not qualifying for payment from the Prescribed Minimum Benefits cover.