

# Advanced Illness Benefit application form

(To be completed by treating doctor)



## Contact details

Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • [www.yourremedi.co.za](http://www.yourremedi.co.za)

## Who we are

Remedi Medical Aid Scheme (referred to as 'Remedi'), registration number 1430, is the medical scheme that you are currently a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes (CMS).

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Remedi and takes care of the administration of your membership.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full and signed by both the doctor and the member (or their proxy).
3. Please return the completed application form to us by email to [aib@yourremedi.co.za](mailto:aib@yourremedi.co.za).
4. If you wish to appeal a decision or if you have any questions, you may call our call centre.
5. Please specify the type of information that each third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.
6. For more information about how and why we use your information, please view our Privacy Statement: <https://www.yourremedi.co.za/wcm/medical-schemes/remedi/assets/legal/privacy-statement-for-remedi-medical-aid-scheme.pdf>

By signing this application, you confirm that the information provided is true and correct.

## 1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Membership number	<input type="text"/>	ID or passport number	<input type="text"/>
Telephone	<input type="text"/>	Cellphone	<input type="text"/>
Email	<input type="text"/>		

## Physical address:

Unit/Suite number	<input type="text"/>	Complex name	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>		
City	<input type="text"/>	Postal code	<input type="text"/>

## 2. About the patient's next-of-kin

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Relationship	<input type="text"/>		
Cellphone	<input type="text"/>	Telephone	<input type="text"/>
Email	<input type="text"/>		







Oxygen	<input type="checkbox"/>	Please specify	<input type="text"/>
Hospice	<input type="checkbox"/>	Please specify	<input type="text"/>
Referral to palliative care doctor	<input type="checkbox"/>	Please specify	<input type="text"/>
Equipment (subject to plan type and review)	<input type="checkbox"/>	Please specify	<input type="text"/>
Other	<input type="checkbox"/>	Please specify	<input type="text"/>


Planned date of next assessment 

D	D	M	M	Y	Y	Y	Y
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**11. Other treating doctors**

Name	<input type="text"/>		
Speciality	<input type="text"/>	Telephone	<input type="text"/>
Email	<input type="text"/>		

Name	<input type="text"/>		
Speciality	<input type="text"/>	Telephone	<input type="text"/>
Email	<input type="text"/>		

I understand what the Advanced Illness Benefit can offer to the patient and that he/she is comfortable to proceed with registration.

Doctor's signature	<input type="text"/>	Date	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

By signing consent, I give permission for the identified next-of-kin to be contacted in order for us to assist with the patient's healthcare needs. I understand that as the patient's condition changes, other care treatment plans may be introduced and I give permission for other multidisciplinary healthcare providers to be contacted.

Member/patient or third party/proxy signature on behalf of the member	<input type="text"/>	Date	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

ECOG Performance Status <sup>1</sup>	Karnofsky Performance Status <sup>2</sup>
0 — Fully active, able to carry on all pre-disease performance without restriction	100 — Normal, no complaints; no evidence of disease 90 — Able to carry on normal activity; minor signs or symptoms of disease
1 — Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work	80 — Normal activity with effort, some signs or symptoms of disease 70 — Cares for self but unable to carry on normal activity or to do active work
2 — Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours	60 — Requires occasional assistance but is able to care for most of personal needs 50 — Requires considerable assistance and frequent medical care
3 — Capable of only limited self-care; confined to bed or chair more than 50% of waking hours	40 — Disabled; requires special care and assistance 30 — Severely disabled; hospitalisation is indicated although death not imminent
4 — Completely disabled; cannot carry on any self-care; totally confined to bed or chair	20 — Very ill; hospitalisation and active supportive care necessary 10 — Moribund
5 — Dead	0 — Dead

Karnofsky Performance Status (recipient age ≥ 16 years) <sup>2</sup>	Lansky Scale (recipient age > 1 year and < 16 years) <sup>3</sup>
<b>Able to carry on normal activity, no special care is needed</b>	<b>Able to carry on normal activity, no special care is needed</b>
100 — Normal, no complaints; no evidence of disease 90 — Able to carry on normal activity; minor signs or symptoms of disease 80 — Normal activity with effort; some signs or symptoms of disease	100 — Fully active 90 — Minor restriction in physically strenuous play 80 — Restricted in strenuous play, tires more easily, otherwise active
<b>Unable to work, able to live at home, cares for most personal needs, a varying amount of assistance is needed</b>	<b>Mild to moderate restriction</b>
70 — Cares for self but unable to carry on normal activity or to do active work 60 — Requires occasional assistance but is able to care for most of personal needs 50 — Requires considerable assistance and frequent medical care	70 — Both greater restrictions of, and less time spent in active play 60 — Ambulatory up to 50% of time, limited active play with assistance/supervision 50 — Considerable assistance required for any active play, fully able to engage in quiet play
<b>Unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly</b>	<b>Moderate to severe restriction</b>
40 — Disabled, requires special care and assistance 30 — Severely disabled, hospitalisation is indicated, although death not imminent 20 — Very ill, hospitalisation and active supportive care necessary 10 — Moribund, fatal process progressing rapidly	40 — Able to initiate quiet activities 30 — Needs considerable assistance for quiet activity 20 — Limited to very passive activity initiated by others (e.g. TV) 10 — Completely disabled, not even passive play

1. Sørensen J, Klee M, Palshof T, Hansen H. Performance status assessment in cancer patients. An inter-observer variability study. *British journal of cancer*. 1993;67(4):773.
2. Schag CC, Heinrich RL, Ganz P. Karnofsky performance status revisited: reliability, validity, and guidelines. *Journal of Clinical Oncology*. 1984;2(3):187-93.
3. Lansky SB, List MA, Lansky LL, Ritter-Sterr C, Miller DR. The measurement of performance in childhood cancer patients. *Cancer*. 1987;60(7):1651-6.