

Contact details

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

Request for additional cover for COVID-19 testing

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 Scheme.

Purpose of form

This application form is to apply for additional cover for COVID-19 testing.

How to complete this form

- Fill in the form in black ink and print clearly, or complete the form digitally.
- Email the completed form to **PMB_APP_FORMS@discovery.co.za**.
- To avoid administrative delays, please ensure this form is completed in full by you and your healthcare professional.

1. Patient details (Main member to complete if patient is a minor)

Name and surname	<input type="text"/>																		
Date of birth	D	D	M	M	Y	Y	Y	Y	Identity number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>																		

The outcome of this application can be communicated to me via Email Fax Post

2. Request for additional COVID-19 testing

Number of additional tests required	Reason for the request

Signature of patient or main member where the patient is a minor

Date

3. Healthcare professional's details (to be completed by the healthcare professional)

First name(s)	<input type="text"/>
Surname	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>
BHF practice number	<input type="text"/>

Healthcare professional's signature	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please only sign if information is true, correct and complete