BMW Employees Medical Aid Society

Administered by Discovery Health

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

Chronic Illness Benefit application form 2026

This application form is to apply for the Chronic Illness Benefit and is only valid for 2026

Who we are

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a not-for-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 BEMAS.

The latest version of the application form is available on www.bemas.co.za. Alternatively members can phone 0860 002 107 and health professionals can phone 0860 44 55 66.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete and sign Section 1 of this form.
3. Take the application form to your doctor to complete section 2, other relevant sections, sign section 8 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
4. Please email the completed application form and all supporting documents to **CIB_APP_FORMS@bemas.co.za** or post it to BMW Employees Medical Aid Society, CIB Department, PO Box 652919, Benmore, 2010.

If you have any questions, please let us know. Once we have assessed your application, we will let you know.

1. Patient's details

Title | Initials

First name(s) (as per identity document)

Surname

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

E-mail

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

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

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

Patient's signature

(if patient is a minor, main member/legal guardian to sign)

Date D D M M Y Y Y Y

Nominate a primary care provider to manage your chronic condition(s)

There is overwhelming medical evidence that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP. You and your dependants need to nominate a primary care GP for the effective management of your chronic conditions.

You and your dependants can change your nomination three times every calendar year. Nominate your GP or manage your existing nomination on www.bemas.co.za.

2. Doctor's details

Name and surname	
Practice number	
Specialty	
Telephone	
E-mail	

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

Member's acceptance and permission

I give permission for my healthcare provider to provide BMW Employees Medical Aid Society and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application. I agree to give permission for you to collect and record information about my condition and treatment, this will also be used to develop registries. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by BMW Employees Medical Aid Society.

2.2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit.

2.3. By registering for the Chronic Illness Benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.

2.4. Funding for medicine from the Chronic Illness Benefit (CIB) will only be effective from when BEMAS receives an application form that is completed in full. I can refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which I am applying.

2.5. A new Chronic Illness Benefit application form needs to be completed when applying for a new chronic condition.

2.6. If I am approved on the benefit, I need to let BEMAS know when my treating doctor changes my treatment plan so my chronic authorisation/s can be updated. I can do this by emailing the new prescription to the email provided or asking my doctor or pharmacist to do this for me. Alternatively, my doctor can log onto HealthID to make the changes, provided that I have given consent. If I do not let BEMAS know about changes to my treatment plan, my claims may not be paid from the correct benefit.

2.7. To make sure that my claims are paid from the correct benefit, the claims from my doctors must be submitted with the relevant ICD-10 diagnosis code(s). I must ask my doctor to include my ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer me to pathologists and radiologists for tests. This will enable pathologists and radiologists.

Consent for processing my personal information

I give BEMAS and the Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.

Consent withdrawal for your Chronic Illness Benefit (CIB)

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable chronic illness benefits. Claims which would usually be funded from the chronic illness benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan.
Should you wish to continue with the consent withdrawal process, then please email **CIB_APP_FORMS@bemas.co.za**.

3. The Chronic Disease List (CDL) conditions covered on BEMAS

BEMAS covers the following Chronic Disease List (CDL) conditions in line with legislation.Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the **website** for more information on what is covered on the benefit and how it is covered.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician
Asthma	None
Bipolar mood disorder	Application form must be completed by a psychiatrist
Bronchiectasis	1. Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician OR 2. Application form completed by a general practitioner - with clinical symptoms and x-ray or CT features in keeping with bronchiectasis
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report that includes the FEV1/FVC post bronchodilator use 2. Please provide additional information when applying for oxygen including: 2.1. arterial blood gas report off oxygen therapy 2.2. . number of hours of oxygen use per day
Chronic renal disease	1. Application form must be completed by a nephrologist, specialist physician or general practitioner 2. Please attach a supporting laboratory report reflecting creatinine clearance or urine albumin creatinine ratio (uACR). General Practitioners - Please attach all laboratory reports from the past six months
Coronary artery disease	None
Crohn’s disease	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist or specialist physician
Diabetes type 1	None
Diabetes type 2	1. Section 7 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Dysrhythmia	None
Epilepsy	1. Application form for newly diagnosed patients must be completed by a neurologist, paediatrician (in the case of a child) or specialist physician OR 2. Application form completed by a general practitioner - with a confirmatory EEG
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	Please attach the diagnosing laboratory report reflecting factor VIII or IX levels
HIV and AIDS (antiretroviral therapy)	Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare programme, please call 0860 002 107
Hyperlipidaemia	1. Section 5 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Hypertension	Application form must be completed by a specialist physician for patients <30 years of age
Hypothyroidism	1. Section 6 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon indicating: 2.1. Relapsing – remitting history 2.2. All MRI reports 2.3. Extended disability status score (EDSS)
Parkinson’s disease	Application form must be completed by a neurologist or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, paediatrician (in the case of a child) or specialist physician
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician
Ulcerative colitis	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon

4. The Additional Disease List (ADL) conditions covered on BEMAS

Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your ADL condition(s) offers cover for medicine for the management of your condition(s). Please refer to the **website** for more information on how medicine is covered on the benefit.

Additional disease list condition	Benefit entry criteria requirements
Ankylosing spondilitis	Application form must be completed by a rheumatologist or specialist physician
Behcet's disease	Application form must be completed by a rheumatologist or specialist physician
Chronic rhinitis	None
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Delusional disorder	Application form must be completed by a psychiatrist
Dermatopolymyositis	Application form must be completed by a dermatologist, rheumatologist or specialist physician
Gastro-oesophageal reflux disease	Applications for newly diagnosed patients must be completed by a gastroenterologist, general surgeon, specialist physician or paediatrician (in the case of a child)
Generalised anxiety disorder	Applications for first line therapy will be accepted from GPs for six (6) months only. Application from a psychiatrist will be required for further cover. Application form must be completed by a psychiatrist for patients <18 years of age
Huntington's disease	Application form must be completed by a psychiatrist or neurologist
Isolated growth hormone deficiency in children <18 years	1. Application form must be completed by an endocrinologist or paediatrician 2. All applications must be accompanied by the relevant laboratory results and growth chart
Major depression	Applications for first line therapy will be accepted from GPs for six (6) months only. Application from a psychiatrist will be required for further cover. Application form must be completed by a psychiatrist for patients <18 years of age
Motor neurone disease	Application form must be completed by a neurologist
Muscular dystrophy and other inherited myopathies	None
Myasthenia gravis	None
Obsessive compulsive disorder	Application form must be completed by a psychiatrist
Osteoporosis	1. All applications must be accompanied by a diagnosing DEXA bone mineral density scan (BMD) report 2. Application form must be completed by an endocrinologist, gynaecologist, rheumatologist, specialist physician or oncologist for patients < 50 years of age 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child)
Panic disorder	Applications for first line therapy will be accepted from GPs for six (6) months only. Application from a psychiatrist will be required for further cover. Application form must be completed by a psychiatrist for patients <18 years of age
Polyarteritis nodosa	Application form must be completed by a rheumatologist
Post traumatic stress disorder	Application form must be completed by a psychiatrist
Psoriatic arthritis	Application form must be completed by a rheumatologist or specialist physician
Pulmonary interstitial fibrosis	Application form must be completed by a pulmonologist or paediatrician (in the case of a child)
Sjogren's syndrome	Application form must be completed by a rheumatologist, nephrologist or specialist physician
Systemic sclerosis	Application form must be completed by a rheumatologist or specialist physician

5. Application for hyperlipidaemia (to be completed by Doctor)

If the patient meets the requirements listed in either A, B, C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis.

A. Primary Prevention

Please **attach the diagnosing lipogram**

Please supply the patient's current blood pressure reading ____ / ____ mmHg

Is the patient a smoker or has the patient ever been a smoker? Yes ☐ No ☐

Please use the Framingham 10-year Risk Assessment Chart as per the 2018 South African Dyslipidaemia Guidelines to determine the absolute 10-year risk of a coronary event and indicate:

Does the patient have a risk of 20% or greater Yes ☐

OR

Is the risk 30% or greater when extrapolated to age 60 Yes ☐

B. Familial hyperlipidaemia

Please **attach the diagnosing lipogram**

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist? Yes ☐

Please attach supporting documentation.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist? Yes ☐

Please attach supporting documentation.

C. Secondary prevention

Please indicate what your patient has:

Diabetes type 2 ☐

Stroke ☐

TIA ☐

Coronary artery disease ☐

Solid organ transplant. Please supply the relevant clinical information in Section D ☐

Chronic kidney disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐

Peripheral arterial disease. Please supply the doppler ultrasound or angiogram ☐

Diabetes type 1 with microalbuminuria or proteinuria ☐

Any vasculitides where there is associated renal disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐

D. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia.

E. Was the patient diagnosed with hyperlipidaemia more than five (5) years ago and the laboratory results are not available? Yes ☐

6. Application for hypothyroidism (to be completed by Doctor)

If the patient meets the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.

A. Thyroidectomy: Please indicate whether your patient has had a thyroidectomy Yes ☐

B. Radioactive iodine: Please indicate whether your patient has been treated with radioactive iodine Yes ☐

C. Hashimoto's thyroiditis: Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis Yes ☐

D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level Yes ☐

OR

A raised TSH but normal T4 level and higher than normal thyroid antibodies Yes ☐

OR

A raised TSH level of greater than or equal to 10 mIU/l on two (2) or more occasions at least three (3) months apart in a patient with a normal T4 level Yes ☐

E. Was the patient diagnosed with hypothyroidism more than five (5) years ago and the laboratory results are not available? Yes ☐

7. Application for diabetes type 2 (to be completed by Doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit.

A. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2.
Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show:

A fasting plasma glucose concentration ≥ 7.0 mmol/l Yes ☐

OR

A random plasma glucose ≥ 11.1 mmol/l Yes ☐

OR

A two hour post-load glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) Yes ☐

OR

An HbA1C ≥ 6.5% Yes ☐

B. Is the patient a type 2 diabetic on insulin? Yes ☐

C. Requests for Metformin Monotherapy
Where member was diagnosed more than five years ago and diagnostic tests are not available may be approved when either of the following is met:

Copy of doctor's patient notes of the diagnostic tests confirming diabetes, with serial HbA1c results (at least annually), Yes ☐

OR

Copy of confirmation of chronic registration for diabetes from previous medical scheme, Yes ☐

OR

Proof of confirmed diabetic microvascular complications e.g: diabetic nephropathy, diabetic retinopathy, or diabetic neuropathy Yes ☐

D. Was the patient diagnosed with diabetes type 2 more than five (5) years ago and the laboratory results are not available? Yes ☐

8. Medicine required (to be completed by doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **date when the condition was first diagnosed** in the table below.

ICD-10 diagnosis code	Condition description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has this patient used this medicine?	
				Years	Months

BEMCIB001

Notes to doctors

8.1. To assist us in paying claims from the correct benefits, please ensure that the date on which the condition was first diagnosed is stipulated in the table above.
8.2. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to BEMAS to ensure payment from the correct benefit.
8.3. Please include the ICD-10 diagnosis code(s) when referring your patient to pathologists and radiologists. This will enable pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.
8.4. We will approve funding for generic medicine, where available, unless you have indicated otherwise.3
8.5. Please
submit all the requested supporting documents with this application to prevent delays in the review process.
8.6. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by emailing the new prescription to us or by logging onto HealthID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature

Date D D M M Y Y Y Y