

Advanced Illness Benefit application form 2026

(To be completed by treating healthcare provider)



Contact us

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • www.medipos.co.za

Who we are

MEDiPOS Medical Scheme, registration number 1548, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

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

Purpose of the form

This form is to apply for palliative care through the Advanced Illness Benefit (AIB) for both advanced oncology (cancer) or for non-oncology conditions.

If the member is not able to complete the form, their proxy must sign it. You can find the Permission to make certain information available to a third party form on www.medipos.co.za.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally.
- Fill in sections 1 to 3 of the application form and sign section 11.
- Take the form to your treating healthcare provider to complete sections 4 to 11. Only applications signed by the treating healthcare provider will be accepted.
- Please return the completed application form to us by email to AIB@medipos.co.za.
- The treating healthcare provider and the patient will receive a letter informing them of our decision and what to do next for approved requests.

Date of application

D	D	M	M	Y	Y	Y	Y
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1. Patient's details

Title	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					Initials	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																
Surname	<input type="text"/>																						
First name(s)	<input type="text"/>																						
ID or passport number	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											Membership number	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
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Email	<input type="text"/>																						
Are you the:	Main member <input type="checkbox"/>	Dependant <input type="checkbox"/>																					
Physical address																							
Unit/Suite number	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					Complex name	<input type="text"/>																
Street number	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					Street name	<input type="text"/>																
Suburb	<input type="text"/>																						
City	<input type="text"/>	Postal code	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>																				

2. About patient's next of kin or emergency contact

Title	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					Initials	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Surname	<input type="text"/>												
First name(s)	<input type="text"/>												

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

3. Advance Health Care Planning

Does the patient have an Advance Care Plan and/or a Living Will? Yes No

**A living will is a legal document that sets out your wishes for your healthcare when you cannot share them yourself. It guides your family and healthcare providers when you are not in a condition to make decisions or express your wishes.*

If "Yes", give the nominated third party's details or the proxy's details.

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

4. About the referring healthcare provider

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

5. About the treating healthcare provider

Same as above	<input type="checkbox"/>			
Surname	<input type="text"/>			
First name(s)	<input type="text"/>			
BHF practice number	<input type="text"/>	Speciality	<input type="text"/>	
Telephone	<input type="text"/>	<input type="text"/>		
Email	<input type="text"/>			

6. Clinical summary for patients with ADVANCED CANCER ONLY (treating healthcare provider to complete)

Date of assessment

D	D	M	M	Y	Y	Y	Y
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Date of cancer diagnosis

D	D	M	M	Y	Y	Y	Y
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ICD-10 code

Main cancer diagnosis

Current Stage TNM

TX T0 T1 T2 T3 T4 NX N0 N1 N2 N3 MX M0 M1

If other, please specify:

Metastasis Yes No Unknown

Site of Metastasis Bone Brain Liver Lung

If other, please specify:

Previous chemotherapy, radiotherapy and surgical interventions

Number of unplanned admissions in the past six months

Have you and your patient discussed why you are applying for this benefit at this stage? Yes No

Other relevant clinical information

Treatment intent Palliative Curative

Disease directed treatment ongoing Yes No

If "Yes", provide the type of treatment e.g. radiotherapy, chemotherapy, targeted therapy.

Details:

If **palliative chemotherapy** is planned, provide details of **exact intent** of treatment, e.g. tumour response, improvement in function, symptom control (Please specify).

Details:

Treatment start date

D	D	M	M	Y	Y	Y	Y
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Planned duration of treatment

If "No", provide the date and details of the last treatment.

Date

D	D	M	M	Y	Y	Y	Y
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Other supportive treatment

Social Worker	<input type="checkbox"/>	Please specify	<input type="text"/>
Counselling	<input type="checkbox"/>	Please specify	<input type="text"/>
Home Nursing (excluding frail care)	<input type="checkbox"/>	Please specify	<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"/>
Bed rentals (subject to benefit option and review)	<input type="checkbox"/>	Please specify	<input type="text"/>
Other	<input type="checkbox"/>	Please specify	<input type="text"/>

Planned date of next assessment

11. Other treating healthcare provider

Name	Speciality	Phone	Email

I understand what the Advanced Illness Benefit (AIB) can offer to the patient and that the patient is comfortable to proceed with registration.

Signature of healthcare provider Date

Please only sign if information is true, complete and correct.

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 / third party / proxy signature on behalf of the patient Date

Please only sign if information is true, complete and correct.

ECOG Performance Status ¹	Karnofsky Performance Status ²
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) ²	Lansky Scale (recipient age ≥ 1 year and < 16 years) ³
Able to carry on normal activity, no special care is needed	Able to carry on normal activity, no special care is needed
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
Unable to work, able to live at home, cares for most personal needs, a varying amount of assistance is needed	Mild to moderate restriction
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
Unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly	Moderate to severe restriction
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.