Bankmed
Yours in good health

Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Chronic Medication Indemnity and Advance Supply Form 2025

For Plus, Comprehensive, Traditional and Core Saver Plans

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

How to complete this form

1. Ensure you use one letter per block, complete with black ink and print clearly. Alternatively, complete it electronically by typing in the fields below.
2. Please include a prescription letter covering the duration of your trip and a copy of your travel ticket or itinerary.
3. Kindly e-mail the completed form to **chronic@bankmed.co.za**
4. To avoid administration delays, please ensure this application is completed in full.

1. Chronic Medication Indemnity

To whom it may concern

Membership number

ID or passport number

Date Y Y Y Y M M D D

Dear Sir / Madam

This is to certify that I, ______ (Principal Member's name and surname)

of ______ (address)

do hereby confirm that I am willing to accept liability for the full payment of the extended prescription for the period of ______ months,

namely ______ (duration)

for ______ (name of member/dependant in need of the medication)

in the event of my ceasing to be a member of Bankmed prior to the expiry of the said prescription.

Signed on this ______ day of ______ 20 ______

Member's signature

Please do not sign an incomplete application form

Witness signature

Please do not sign an incomplete application form

2. Request for Advance Supply of Chronic Medication

Membership Information

Membership number

Plan Type

Name of the Principal Member

Name(s) of dependants who are travelling

Departure date from South Africa D D M M Y Y Y Y

Return date to South Africa D D M M Y Y Y Y

I will require ______ (number of months) advance supply of my chronic medication and I will be collecting the medication from ______ (Pharmacy name) between the following dates ______ and ______

(Please supply the dates within a five day period during which it will be convenient for you to collect the advance supply of chronic medication from the pharmacy).

Please note that the medication may only be claimed within this five day period.