Advanced Illness Benefit application form 2025

(To be completed by treating doctor)

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, 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 Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, www.discovery.co.za, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

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.discovery.co.za > Medical aid > Find documents and certificates.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on www.discovery.co.za, under Medical Aid > Find documents and certificates > Application forms.
  All relevant sections must be physically signed by both the treating doctor and the member/patient or their proxy and cannot be signed digitally. The member/patient or proxy must sign and date any changes.
- Fill in section 1 to 3 of the application form and sign section 11.
- Take the form to your treating doctor to complete section 4 to 11. Only applications signed by the treating doctor will be accepted.
- Please return the completed application form to us by email to **AIB@discovery.co.za.**
- The treating doctor and the patient will receive a letter informing them of our decision and what to do next for approved requests.
- You may call us if you would like to lodge a formal dispute or if you wish to appeal a decision.

Date of application D D M M Y Y Y Y

1. Patient's details

Title | Initials

First names

Surname

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

Are you the: Main member ☐ A dependant ☐

Physical Address

Suite/Unit number | Complex name

Street number | Street name

Suburb | Postal code

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

Title Initials

First name(s)

Surname

Relationship

Email

Cellphone Telephone

Title Initials

First name(s)

Surname

Relationship

Email

Cellphone Telephone

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 Initials

First name(s)

Surname

Relationship

Email

Cellphone Telephone

4. About the referring doctor

First name(s)

Surname

BHF practice number

Speciality

Telephone

Email

Preferred method of communication

Practice address

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

5. About the treating doctor

Same as above ☐

First name(s)

Surname

BHF practice number

Speciality

Telephone

Preferred method of communication

Email

Practice address

Suite/Unit number

Complex name

Street number

Street name

Suburb

Postal code

6. Clinical summary for patients with advanced cancer only (treating doctor to complete)

Date of assessment D D M M Y Y Y Y

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

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.

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

Planned duration of treatment

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

Date D D M M Y Y Y Y

7. Clinical summary for patients with NON-ONCOLOGY CONDITIONS (treating doctor to complete)

Date of assessment D D M M Y Y Y Y

Date of diagnosis D D M M Y Y Y Y ICD-10 code

Main diagnosis

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

Treatment to date

Other relevant clinical information including any functional classification scoring system related to the condition e.g. NYHA and pathology results

Treatment intent Palliative Curative

8. Performance status (treating doctor to complete for patients ≥ 16 years)*

Current Performance status*		**Performance status 6 months ago***	
ECOG Performance Status [1]		ECOG Performance Status [1]	
Karnofsky Performance Scale [2]		Karnofsky Performance Scale [2]	

*Refer to page 7 for more information

9. Performance status (treating doctor to complete for patients < 16 years)*

Current Performance status*		Performance status 6 months ago*	
Lansky Scale 3		Lansky Scale 3	

*Refer to page 7 for more information

10. Palliative care plan (treating doctor to complete)

Medicine

Item	Dose	Frequency	Duration	Repeat

Other supportive treatment

Social Worker	☐	Please specify	
Counselling	☐	Please specify	
Home Nursing (excluding frail care)	☐	Please specify	
Oxygen	☐	Please specify	
Hospice	☐	Please specify	
Referral to palliative care doctor	☐	Please specify	
Equipment (subject to plan type and review)	☐	Please specify	
Other	☐	Please specify	

Planned date of next assessment D D M M Y Y Y Y

11. Other treating doctors

Name		**Speciality**		**Phone**		**Email**	
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 doctor

Date D D M M Y Y Y Y

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 D D M M Y Y Y Y

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.