



### Request for additional cover for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2026

Please complete this form if you want to request additional cover for your approved Chronic Disease List (CDL) condition.

#### Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578. This 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 the Scheme.

#### How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administrative delays, please ensure this form is completed in full by you and your doctor.
3. Once complete, please email your form to **CIB\_APP\_FORMS@tfgmedicalaidscheme.co.za**.

#### 1. About the patient (member to complete if patient is a minor)

Surname	<input type="text"/>																					
First name(s) (as per identity document)	<input type="text"/>																					
ID or passport number	<input type="text"/>	Date of birth	D	D	M	M	Y	Y	Y	Y												
Membership number	<input type="text"/>	Telephone (W)	<input type="text"/>																			
Telephone (H)	<input type="text"/>	Cellphone	<input type="text"/>																			
Email	<input type="text"/>																					

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

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

Patient's signature	<input type="text"/>	Date	D	D	M	M	Y	Y	Y	Y
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(if patient is a minor, main member to sign)

#### 2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultation or procedures required per year	Supporting information for the request



### 5. Doctor's details (doctor to complete)

Surname	<input type="text"/>														
Name(s)	<input type="text"/>														
Practice number	<input type="text"/>	Speciality	<input type="text"/>												
Telephone	<input type="text"/>														
Email	<input type="text"/>														
The outcome of this application will be communicated to you by email.															
Doctor's signature	<input type="text"/>							Date	<input type="text"/>						