military veterans
Department:
Military Veterans
REPUBLIC OF SOUTH AFRICA

BENEFIT ACCESS FORM: HEALTH CARE

MILITARY VETERANS ACT18 of 2011, SECTION 5 (1) (i).

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FORCE NUMBER/SERIAL NUMBER

INSTRUCTIONS

- You are applying for Health Care Benefit
- You should ONLY apply for this benefit if you are registered on the database of the Department of Military Veterans.
- Currently, Health Care is only available to military veterans
- To check if you are registered call 080 232 3244
- It is illegal to submit a fraudulent claim, including not disclosing details of your employment medical aid, criminal records or pension from other state institutions.

This application form is free. Do not Pay any amount to anyone

Email to Health.Care@dmv.gov.za

PERSONAL DETAILS (TO BE COMPLETED BY MILITARY VETERAN OR APPLICANT

Surname					
Full Names			Initials		
Identity Number			Gender	M	F
Date of Birth		Cell Number			
Residential Address					
		Postal Code			
Email Address		Cell No.			
Are you 60 years or above	Yes	No			Divorced

If married, provide the following details of your spouse

Surname		Initials	
Cell Number			

DEPENDENTS

SURNAME	INITIALS	IDENTITY NUMBER

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A military veteran convicted of rape, murder, robbery, theft or high treason committed after 27 April 1994 and sentenced to imprisonment for a period exceeding 5 years without option of a fine is disqualified from receiving any benefits in terms of the Act.

QUALIFICATION CRITERIA FOR HEALTH CARE TO BE COMPLETED BY THE MILITARY VETERAN

Do you have a conviction for a crime after 27 April 1994?			YES	NO
If you answered Yes	What were you convicted for? Circle relevant Offence			Rape , Murder Robbery Theft High Treason
	Imprisonment period		Fine	R
Employment Status	Unemployed	Contract	Permanent	Self Employed

Name of Employer if not Unemployed/Self Employed						
Contact Number of Employer						
Do you have a medical Aid?	Y	N	Med Aid No			
Name of Medical Aid						
Medical Aid Option						
Do you qualify for Medical Subsidy from your Employer	Y	N				
Did you Voluntarily Resign as a Regular Force Medical Continuation Fund Member (RFMCF)			Y	N	When?	
Did you take pay out?	Y	N				

Will the RFMCF membership continue at age 60? Y N

If No, any statements or Motivation?

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DECLARATION AND CONSENT

I, the undersigned (*Full Names*)

.....

I consent to and authorise the Department of Military Veterans to contact any person or entity for purposes of obtaining or verifying such information or documentation related to my application for the Military Veterans Health Care Benefit.

I am the applicant whose details appear in this application form. The content of the said benefit access form falls within my personal knowledge, unless stated otherwise, and are both true and correct.

_____ _____

APPLICANT'S SIGNATURE **IDENTITY NUMBER**

DATE:...../...../.....

PLEASE ATTACH THE FOLLOWING DOCUMENTS

	Application form		
	Certified Identity Documents		
	Birth Certificates		
	Marriage certificate		
	Death Certificate		
	Medical Aid Certificate		
	Affidavit 1. Confirming Unemployment and No Medical Aid Benefits 2. Confirm that you have no criminal records: not convicted for Rape, Murder, Robbery, High treason and theft 3. Confirm that you have not been convicted for any of the above for more than 5 years without an option of a fine (refer to the DMV Regulations)		
	Any other documents		