APPLICATION FORM
ADVANCE SUPPLY OF CHRONIC MEDICATION

Please complete this application form if you have any circumstances, such as plans to travel outside of the country for an extended period, and you need to request an advance supply of medication from your doctor/pharmacy. Please provide supporting documentation as proof, such as flight bookings.

1. DETAILS OF APPLICANT

Membership number		Dependant code	
Full name and surname			
Identity number		Contact number	
Email address			

2. PRESCRIPTION DETAILS

Reason for advance supply request

Medication name and details

Time period of advance supply required (days/weeks/months)

I hereby confirm that, in the event that I am no longer a member of Wooltru Healthcare Fund prior to the expiry of this prescription, I am willing to accept liability for the full payment of the extended prescription for the period indicated.

Member's signature		Witness' signature	
Date	DD/MM/YYYY	Date	DD/MM/YYYY

Please return the completed form by email to chronic@wooltruhealthcarefund.co.za.

12/2021

Chronic Medication Risk Management Programme

Post Chronic Medication Risk Management Programme, PO Box 15079, Vlaeberg 8018
Tel 0800 765 432 (Network Option members) | 0802 228 922 (Saver and Comprehensive Option members)
0861 888 346 (doctors and pharmacists for Saver and Comprehensive Option members only)
Email chronic@wooltruhealthcarefund.co.za **Website** www.wooltruhealthcarefund.co.za