momentum
health

Individual application for membership

2017

Important notes:

- Momentum Health is a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Momentum Health is administered by a separate company, MMI Health (Pty) Ltd (Administrator), a division of MMI Group Limited.
- Please do not resign from your current medical scheme until you have received written notification of acceptance from Momentum Health.
- Momentum Health will only consider membership on receipt of a fully completed application form.
- Please provide the ID number and copy of ID for the principal member and all dependants.
- Please ensure that the first name and surname of the principal member, spouse and dependants are completed in accordance with the ID or passport.
- Please provide certificates of membership for previous schemes, where applicable.
- Please submit the completed and signed form via fax to **031 580 0430** or email at **healthnewbusiness@momentumhealth.co.za**.
- Should we not receive all the required supporting documents, it will delay the finalisation of your application.

Section 1: Personal details

Principal member

Title Initials First name

Surname

Previous surname Gender Male Female

ID/Passport number Date of birth D D – M M – Y Y Y Y

Country in which passport was issued

Country of residence

Marital status Single Married Separated Divorced Widowed

Home address

Postal code

Postal address (if different)

Postal code

Telephone - home Cellphone number

Email address

Please note that the email address you provide will be used when the Scheme communicates with you.

Spouse or partner (If spouse or partner is also applying for membership)

Title Initials First name

Surname

Previous surname Gender Male Female

ID/Passport number Date of birth D D – M M – Y Y Y Y

Country in which passport was issued

Country of residence

Telephone - home Cellphone number

Email address

Section 1: Personal details (continued)

Dependants (If dependants are also applying for membership)

Dependant 1

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued

Date of birth D D – M M – Y Y Y Y Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes No Dependant's monthly income R

Dependant 2

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued

Date of birth D D – M M – Y Y Y Y Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes No Dependant's monthly income R

Dependant 3

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued

Date of birth D D – M M – Y Y Y Y Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes No Dependant's monthly income R

Dependant 4

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued

Date of birth D D – M M – Y Y Y Y Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes No Dependant's monthly income R

Section 2: Employer information

Section 2.1: Non-government employees

Company name

Branch name

Existing group number — Employee number

Business telephone number — Date of employment D D – M M – Y Y Y Y

Section 2.2: Government employees

Name of department

Persal number * — Date of employment D D – M M – Y Y Y Y

* Please attach a copy of your latest payslip if you are paying your contributions via Persal and do not complete Sections 9 and 10.

Section 3: Business information if self-employed

Company name

Registration number — Registration date D D – M M – Y Y Y Y

Nature of business

Telephone - work — Fax number

Cellphone number — Preferred method of communication E-mail Post

Email address

Business physical address

Postal code

Business postal address (if different)

Postal code

Section 4: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no

Signature of financial adviser — **Date** D D – M M – 2 0 Y Y

How would you like to receive the welcome pack? Mail to member Send to branch* * Internal branch code

Section 5: Previous medical scheme information

List each medical scheme that you have been a member of (note that only medical schemes registered in South Africa apply). This information needs to be supplied for the principal member and all dependants applying for membership. If more space is required, please include additional pages.

Please provide certificates of membership for previous schemes.

Name of member	Name of scheme	Membership number	Date joined yy/mm/dd	Date terminated yy/mm/dd or current

Are the details completed above the same for all dependants applying for cover? Yes No

If no, please provide details in the space above.

Have you been forced to change your medical scheme due to no longer being eligible to remain on your current scheme? Yes No

If yes, please include a certificate of membership from your current scheme, along with proof of the forced move (such as copy of resignation letter).

Section 6: Medical details

Please make sure that you have completed Section 5 before completing this section.

Principal member

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Spouse or partner

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 1

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 2

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 3

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 4

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Doctor/s consulted in the past 12 months

If your family has consulted more than one doctor in the past 12 months, please list all doctors that you consulted.

Name and surname

Telephone - work How long has he/she been your doctor (years)?

Name and surname

Telephone - work How long has he/she been your doctor (years)?

Name and surname

Telephone - work How long has he/she been your doctor (years)?

If you or any of your dependants are living with HIV/Aids.

If you would prefer not to disclose the nature of the HIV-status on this form due to confidentiality, you may wait until you have received your valid Momentum Health membership number. On receipt of your membership number, you have 14 working days to contact LifeSense Disease Management on 0860 50 60 80 in order to notify us that you or your dependants are living with HIV/Aids, failing which your membership may be terminated for nondisclosure. This information will be kept confidential.

☐ Tick here to indicate that you have read the disclaimer, and that the same information has been shared with all your dependants included on the application form.

Section 6: Medical details (continued)

Section 6.1

Complete this section if you have been a member of a medical scheme registered in South Africa for at least 24-months and less than 90 days have passed since your resignation from that scheme. If not, please complete Section 6.2.

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

In the last 12 months, have you or your dependants had any of the following:

6.1.1	Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months?	Yes	No
6.1.2	Have you or your dependants had an operation or admission to any hospital in the last 12 months?	Yes	No
6.1.3	Are you or your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months?	Yes	No
6.1.4	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months?	Yes	No
6.1.5	Is there any other condition or symptom, which is not detailed in any question above, that you or any of your dependants have experienced and for which you have not yet sought medical advice?	Yes	No

All questions must be answered with a 'Yes or 'No'. If 'Yes' to any question, please provide full details below. If more space is required please include additional pages.

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 6.2

Complete Section 6.2 if:

- **you have not been a member of a medical scheme registered in South Africa for more than 90 days; or**
- **you have been a member of a medical scheme registered in South Africa for less than 24-months and less than 90 days have passed since your resignation from that scheme.**

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

All questions must be answered with a 'Yes' or 'No'. If 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

In the last 12 months, have you or your dependants had any of the following:

6.2.1 **Disorders or problems with the heart or cardiovascular system.** E.g. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.2 **Respiratory or lung trouble.** E.g. tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver.** E.g. gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis,cirrhosis, liver failure, or have you ever had a gastroscopy, colonoscopy, or other special examinations? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs.** E.g. abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections, or sexually transmitted disease? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 6: Medical details (continued)

Section 6.2 (continued)

6.2.5 **Disorders of the nervous system or brain.** E.g. epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have you or any of your dependants had or been advised to have an MRI or CT scan? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.6 **Mental disorders.** E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, post-traumatic stress disorder or substance abuse? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.7 **Ear, nose, throat or eye disorders.** E.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs or spine.** E.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint trouble, multiple sclerosis, any joint problems or replacements, acne, eczema or psoriasis? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.9 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.10 **Cancer,** a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant. Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.11 Are you or any of your dependants currently undergoing, or anticipating any specialised dental/maxillo facial treatment? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.12 Are you or any of your dependants taking ongoing medication for any condition not listed in any other question? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.13 Have you or any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.14 Are you or any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 6: Medical details (continued)

Section 6.2 (continued)

6.2.15 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.16 Is there any other condition or symptom, which is not detailed in any other question, that you or any of your dependants have experienced and for which you have not yet sought medical advice? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Questions 6.2.17 to 6.2.18 apply to female applicants

6.2.17 Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant? Yes No

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.18 Are you or any of your dependants currently pregnant? Yes No

Section 7: Option choice

Important note: The option you choose may only be changed with effect from 1 January of each year, by submitting an option change form to Momentum Health before the end of November of the previous year.

Ingwe Option [ ]

Hospital provider	Chronic and Day-to-day provider		Income	
State hospitals	Ingwe Primary Care Network provider	[ ]	R11 001 +	[ ]
Ingwe Network	Ingwe Primary Care Network provider	[ ]	R8 201 - R11 000	[ ]
Any hospital	Ingwe Active Primary Care Network provider	[ ]	R6 101 - R8 200	[ ]
			R651 - R6 100	[ ]
			≤ R650	[ ]

Provider's practice number

Provider's practice name

*If less than R11 001, please complete the **Declaration of Income**

You need to nominate a doctor listed on the Momentum Health Ingwe or Ingwe Active Primary Care Network for all your day-to-day and chronic healthcare needs. To view the lists of providers, please visit www.momentumhealth.co.za or call us on 0860 11 78 59.

Access Option [ ]

Hospital provider
Access Network

Chronic and Day-to-day provider
Access Primary Care Network

Provider's practice number

Provider's practice name

You need to nominate a doctor listed on the Momentum Health Access Primary Care Network for all your day-to-day and chronic healthcare needs. To view the lists of providers, please visit www.momentumhealth.co.za or call us on 0860 11 78 59.

Custom Option [ ]

Hospital provider		Chronic provider	
Any hospital	[ ]	Any	[ ]
Associated hospitals	[ ]	Associated GP and Courier Pharmacies	[ ]
		State	[ ]

Incentive Option [ ]

Savings: 10%

Hospital provider		Chronic provider	
Any hospital	[ ]	Any	[ ]
Associated hospitals	[ ]	Associated GP and Courier Pharmacies	[ ]
		State	[ ]

Section 7: Option choice (continued)

Extender Option	**Hospital provider**	**Chronic provider**	**Savings: 25%**
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	
Pay day-to-day claims at:	Accumulation rate	Up to 200% of the Momentum Health Rate	

Summit Option	**Hospital provider**	**Chronic and Day-to-day provider**
	Any hospital	Freedom-of-choice

Section 8: Banking details for payment of contributions

You do not need to complete this section if your employer is paying for your Momentum Health contributions (as per the company application form).

(Please do not provide credit card details. Momentum Health is not allowed to record your credit card details.)

Name of account holder

Name of bank

Account number

Account type Current/Cheque Savings Transmission

Branch code - - - Branch name

Section 9: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. Momentum Health will debit the bank account for contributions on the 1st working day of every month. I understand that Momentum Health bills for contributions in advance and dependent on my commencement and activation dates there may be more than a single contribution payable to the Scheme.

If an **individual's** account is to be debited:

If a third party's account details are used, please provide a copy of their ID.

Signature of account holder **Date** D D – M M – 2 0 Y Y

If a **company** account is to be debited:

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- Momentum Health may bill us for the amount due for this member in the same manner as for other members that our organisation employs.

Please note that if the company is paying contributions for more than one employee, a company application form needs to be submitted if the company is not already listed as an employer on Momentum Health.

Name

Position in company

Signature of account holder/ Authorised signatory **Date** D D – M M – 2 0 Y Y

Company stamp

Section 10: Banking details for claim refunds payable to member

You, as the principal member, need to sign this section if a third party's bank details are being used for claims reimbursement. If a third party's account details are used, please provide copy of their ID.

☐ Tick this box if we may use the same bank account details provided for your Momentum Health contribution payments.

If not, please complete the bank details below.

(Please do not provide credit card details. Momentum Health is not allowed to record your credit card details)

Name of account holder

Name of bank

Account number

Account type Current/Cheque Savings Transmission

Branch code - - - Branch name

Signature of principal member **Date** D D – M M – **2 0** Y Y

Section 11: Consent for Momentum Health to process personal information

Momentum Health and the Administrator are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. We request your consent to process your personal information and obtain your personal information from any other person for the purposes set out in this section. While your consent is voluntary, it is a requirement for your membership.

1. The personal information we require relates not only to you but also to your child and adult dependants, and you confirm that you are authorised to provide consent in this section on behalf of your dependants on Momentum Health.
2. You authorise, and give consent to, Momentum Health and the Administrator to collect, store, collate, process, share and further process your personal information, including health information, and that of your dependants, for purposes of your membership of Momentum Health, risk profiling and management and as set out in this section.
3. If you have consented to the disclosure of your personal information to any other entity or person (person means any natural or juristic person, firm, company, corporation, state, agency or organ of a state, association, trust or partnership, whether or not having legal personality) or if a contractual relationship exists between Momentum Health or the Administrator which requires Momentum Health or the Administrator to provide your personal information to any other person, Momentum Health or the Administrator may do so.
4. You must give Momentum Health and the Administrator all information and evidence they may require from time to time for the purposes of assessing this application, your membership of Momentum Health, risk profiling or management. You authorise Momentum Health and the Administrator to obtain, from any person, including any medical doctor or other healthcare provider who has attended you or your dependants in the past or who will attend to you or your dependants in the future, any information we may require concerning you or any of your dependants in assessing any risk or claim in relation to this application, your membership of Momentum Health, risk profiling or management and you consent to that person providing, and instruct that person to provide, Momentum Health and the Administrator with this information on request. You waive the provisions of any law or regulation that restricts the disclosure of this information. You must also submit to any examination by Momentum Health's medical assessor as and when Momentum Health requires this.
5. You understand that your personal information will be shared between Momentum Health, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to your membership of Momentum Health and:
   - to grant you access to interact with Momentum Health on its website; and
   - to provide any credit bureau or registered credit provider with your credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
6. You agree that Momentum Health's Administrator, MMI Health, a division of MMI Group Limited, may use your information for the purpose of marketing (including direct marketing) of insurance, investments, health insurance, retirement benefits, other financial services and health related products offered by MMI and it subsidiaries. Tick here if you do not wish to receive any direct marketing. ☐

Signature of principal member **Date** D D – M M – **2 0** Y Y

Section 12: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by MMI Health (Pty) Ltd. (Administrator) and agree to familiarise myself with, and be bound by, the Rules of the Scheme (the Rules) if my application for membership is accepted. I understand that I may request to inspect the Rules and that, in the event of a dispute, the Rules will be decisive.
2. I acknowledge that if my dependants and I do not disclose all the information that is relevant to the assessment of this application or if I and my dependants submit fraudulent claims, it will make any contracts to which this application relates null and void. The Scheme may, at its discretion, retain all contributions or recover any amounts paid to me or any service provider on my behalf.
3. I will notify the Scheme of any changes that take place, in any circumstances on which the Scheme based its assessment of its risk (including my health status), after the date of this application form and prior to my joining date. I acknowledge that failure to do so will result in the termination of my contract with the Scheme. In such event, the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on my, or my dependants' behalf, under such contract.
4. I understand that this application form is valid for 30 days only from the date of signature.
5. I am aware that this application must be accompanied by proof of identification for me and my dependants in order for the application to be assessed.
6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contributions as well as any other amounts I owe to the Scheme.
   - Non-receipt of contributions will result in suspension of medical scheme benefits for my entire contract. This suspension will last until I have paid all outstanding contributions.
     - I understand that whilst my contract is suspended, the Scheme will not honour any claims related to services rendered for the period that the membership is suspended.
     - I understand that I will remain fully liable to pay contributions for the period of suspension.
   - Non-payment of more than one month's contribution will result in termination of my membership of the Scheme.
   - Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection.
7. If the employer is responsible to pay my medical scheme contributions, I authorise and instruct my employer to:
   - deduct from my remuneration (and any other sums due to me) any amounts that I may owe to the Scheme from time to time; and
   - pay such amounts to the Scheme.

   I also authorise and instruct any person (such as my employer, a pension fund or provident fund) who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in the first sentence of this clause to the Scheme as and when it is due. Furthermore, I understand that I will be liable for any legal costs that may be incurred by any party in the recovery of any amount that I owe to the Scheme.
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection. Refer to point 6.
9. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that existed for a period of up to twelve (12) months prior to my application to join the Scheme.
10. I acknowledge that the Scheme has the right to apply a three-month general waiting period, a twelve-month exclusion on a pre-existing condition, and/or Late-joiner contribution penalty, where applicable.
11. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 6, on pg 4).
12. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.
13. I undertake to give a calendar month's notice should I wish to terminate my membership.
14. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and / or Administrator against any claim which may arise as a result of my failure to do so.
15. Words used in this application have the meaning that the Rules give them.
16. I consent to the recording of all conversations between me and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I also consent to all these records remaining the sole property of the Scheme and the Administrator.
17. I acknowledge that my duly appointed financial adviser will have access to my membership information and that this access will stay in-force until I notify the Scheme of a change in financial adviser.
18. I understand that I need to provide full and complete information, even if I have already done so for other policies held with any of the subsidiaries of MMI Group Holdings Limited, as Momentum Health and MMI Holdings are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants and I are accepted as members of the Scheme, my answers on this application will form the basis of our membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser, or any other third party on my behalf.**

Section 12: Terms and conditions (continued)

Should Momentum Health confirm your start date or terms of acceptance before activation?* Yes No

* Where waiting periods and/or Late Joiner Penalties apply to your membership, you will be required to sign an acceptance letter before Momentum Health activates your membership.

Signed at

Starting date* 0 1 – M M – 2 0 Y Y

* Remember to inform us should any information provided on this form change between the date of signing the form and the starting date.

Signature of principal member **Date** D D – M M – 2 0 Y Y

Momentum Health 1-3 Canegate Road La Lucia Ridge 4019 PO Box 2338 Durban 4000 South Africa
Client Service and Authorisation 0860 11 78 59 member@momentumhealth.co.za www.momentumhealth.co.za
Registered in terms of the Medical Scheme Act No 131 of 1998

momentum

Application for complementary products

2017

Important notes:

- As a Momentum Health member, you can choose to make use of additional products available from Momentum Group (Momentum), a division of MMI Group Limited, to seamlessly enhance your medical aid. Please note that Momentum is not a medical scheme, and is a separate entity to Momentum Health. You can be a member of Momentum Health without taking any of the complementary products that Momentum offers.
- If you choose to take any of these products, please complete the contract details for each product you require.

Section 1: Multiply contract details

Section 1.1

☐ Tick this box if you would like to join Multiply Premier.

Contributions will be calculated based on your medical aid membership composition:

- Single member R195
- Family of two R235
- Family of three or more R265

How would you like to receive your Multiply welcome pack? Mail Member to collect Branch Financial adviser to collect

Section 1.2: Financial adviser for Multiply membership

Please complete this information if commission should be split between financial advisers.

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %

Signature of financial adviser **Date** D D – M M – 2 0 Y Y

Section 2: HealthSaver contract details

You can use this account as you see fit to make provision for additional healthcare expenses.

Section 2.1: Free HealthSaver account

☐ Tick this box if you would like Momentum to activate your free HealthSaver account.

Section 2.2: HealthReturns

☐ Tick this box if you want your HealthReturns to be paid into your HealthSaver account.

(And be eligible for HealthReturns Booster. If you do not select this option, HealthReturns will be paid into your bank account.)

Section 2.3: Monthly HealthSaver

☐ Tick this box if you want to start contributing to your HealthSaver and complete your chosen amount below:

Monthly amount R Minimum of R100 per month

You can choose to contribute any amount in addition to the regular monthly payments. These additional amounts can be paid via Electronic Fund Transfer (EFT).

Section 2: HealthSaver contract details (continued)

Section 2.4: Apply for credit

☐ Tick this box if you want to apply for credit on the above monthly amount and complete the information below.

Credit assessment inventory (complete if you are applying for credit on your monthly contributions)

Joint gross monthly household income subtotal	R
Joint monthly household expenses	
a) Discretionary expenses (e.g. movies, eating out)	R
b) Contractual expenses (e.g. car repayments, retail accounts)	R
Expenses subtotal	R
Net monthly income	**R**

Credit provider information

In terms of the regulations of the National Credit Act 34 of 2005, the following information must be supplied.

NCR number	NCR CP 173
Name of credit provider	MMI Group Limited
Physical Address	268 West Avenue Centurion Gauteng 0157
Contact number	0860 11 78 59 Weekdays 08:00 to 17:00

Section 2.5: Claims payment

In-hospital claims:

☐ Tick this box if you do not want any shortfalls in your in-hospital claims to be paid automatically from your available HealthSaver funds.

Day-to-day claims:

You can choose how your day-to-day claims will be paid from your available HealthSaver funds.

☐ Tick this box if you want your claims to be paid in full

☐ Tick this box if you want your claims to be paid at up to a maximum of 200% of the Momentum Health Rate

Section 3: AdviceFee contract details

Please select one of the following AdviceFee options:

☐ Tick this block if you would like to include AdviceFee.

Standard monthly amount R41 R75 R100 R119 Increase option Annual Increase

Section 4: HealthWaiver

Section 4.1 Insured life/lives

☐ Tick this block if you would like to apply for a HealthWaiver policy.

Insured life/lives Principal member Spouse

Section 4.2 Contract details

Benefit payment term 5 years 10 years

Have you smoked or used any other form of tobacco in the past twelve months?

Principal member Yes No Spouse Yes No

Section 4: HealthWaiver (continued)

Section 4.2 Contract details (continued)

Medical disclaimer

Have you suffered from or do you currently suffer from or take any chronic treatment for any disease, for example cancer, cardiovascular, kidney disease, stroke, HIV/Aids, respiratory, neurological or connective tissue disease?

Principal member Yes No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No

Spouse Yes No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No

Exclusion for pre-existing condition

All claims arising from any physical defects, illnesses, bodily injuries or diseases that the insured life suffered from, was aware of, or has received medical treatment or advice for in the three years prior to the starting date of a qualifying benefit, are excluded for the first three years from the starting or restarting date of that benefit. If no such qualifying benefit exists, the 3-year period will apply to the starting date of this benefit. If the principal member upgrades his options under his medical aid membership or adds new dependants (except as a result of marriage or childbirth) to his medical aid membership, a new 3-year period will apply to the increase in the medical aid contribution from the date of the increase.

Please read the clause below carefully. It contains provisions that potentially compromise your rights.

1. Any physical defect, illness, bodily injury or disease that I or my dependants suffered from, were aware of or received treatment for in the past three years is considered a pre-existing condition.
2. I understand that any claim due to a pre-existing condition will not be covered for the first three years from the starting or re-starting of a qualifying benefit.
3. If no such qualifying benefit exists, the three year period will apply to the starting date of this benefit.
4. If I, as the principal member, upgrade my options under my medical aid membership or add new dependants (except as a result of marriage, childbirth or adoption) to my medical aid membership, a new three year period will apply to the increase in my medical aid contribution from the date of the upgrade.

I have read and understand the above clause, have had an opportunity to question and consider it and I agree to the consequences of it.

Signature of principal member **Date** D D – M M – 2 0 Y Y

Signature of spouse **Date** D D – M M – 2 0 Y Y

Section 4.3 Start of policy

The starting date will depend on the starting date of your medical aid membership. This policy cannot have a starting date that is earlier than the medical aid starting date.

Section 4.4 Replacement of insurance

Does this application replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance discontinued within the last four months or within the next four months)? Yes No

If Yes, the financial adviser must discuss and complete the *Replacement Policy Advice Record* (MYRIAD 013).

Important note: The replacement of any insurance has various potentially detrimental consequences which your financial adviser should disclose to you. **Momentum will not automatically cancel a Momentum policy/policies on acceptance, unless the client submits a conditional termination form with this application form.**

Declaration by the financial adviser

I hereby declare that I have requested and recorded the client's response to the above question with regard to replacement and that the client is fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I further declare that, irrespective of the client's response to the question with regard to replacement, that I have explained the following to the client:

1. The meaning of replacement,
2. That a replacement is potentially prejudicial, and
3. That where a replacement is considered, the client is legally entitled to comprehensive information regarding the consequences of replacement.

Signature of financial adviser **Date** D D – M M – 2 0 Y Y

Section 4: HealthWaiver (continued)

Section 4.5 Policy Holder details

Name of legal entity

Contact person in case of legal entity

Registration number — Registration date D D – M M – Y Y Y Y

Postal address

Postal code

Telephone - work — Fax number

Cellphone number

Email address

Preferred method of communication: Email / Post

Tax status: Company / Close Corporation (M) / Natural persons (N) / Non-taxable institution (I)

Tax status of trust beneficiaries if the applicant is a trust company: Company (C) / Natural persons (P) / Non-taxable institution (Z)

Section 5: Banking details for payment of contributions

Please indicate the contribution payer for each of the complementary products applied for:

Contribution payer	**Multiply**	**HealthSaver**	**AdviceFee**	**HealthWaiver**
Principal Member				
Company (as per company application form)				

(Please do not provide credit card details. Momentum is not allowed to record your credit card details)

Name of account holder

Name of bank

Account number

Account type: Current/Cheque / Savings / Transmission

Branch code - - - Branch name

Section 6: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

I authorise Momentum to debit the account as supplied on this application form with the amount of the contribution that I have agreed to pay per complementary product. I undertake to inform Momentum of any change in the account details. I authorise Momentum to verify such account details with my financial institution. I accept that Momentum may debit the account on a date other than specified.

If an **individual's** account is to be debited:

If a third party's account details are used, please provide a copy of their ID.

Signature of account holder — **Date** D D – M M – 2 0 Y Y

If a **company** account is to be debited:

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- Momentum may bill us for the amount due for this member in the same manner as for other members that our organisation employs.

Name

Position in company

Signature of account holder/ Authorised signatory — **Date** D D – M M – 2 0 Y Y

Company stamp

Section 7: Terms and conditions

For protection of personal information

MMI comprises companies that provide the following products and services:

- financial planning services, healthcare administration, insurance products, investment products, managed care services and retirement benefits.

MMI is committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. To deliver an integrated value proposition across all the products available from MMI, we need your consent to share your and your child and adult dependants' personal information between the subsidiaries of MMI and contracted third parties both locally and outside the Republic of South Africa who require this information.

1. You confirm that you are authorised to provide consent in this section on behalf of your dependants.
2. You authorise and give consent to MMI to process, further process and share your personal information, including health information, and that of your dependants, for purposes of any products and services with the subsidiaries of MMI.
3. The personal information will be shared to provide for the following purposes:
   - to interact with, and view all the products and services you have with the MMI group of companies on its websites,
   - to provide your and your dependants' personal and health information to any other entity within the MMI Group, where you and/or your dependants already have a relationship or where you and/or your dependants have applied for a product or benefit, for the administration, underwriting and risk profile analysis of you and/or my dependants' products or benefits.

Declaration

I am aware that I may withdraw my permission given above to share my and/or my dependants' information with MMI and its subsidiaries, except if the disclosure thereof is necessary for the administration of the product or services provided or is required in terms of legislation or to give effect to the implementation of an agreement for my or any of my dependants' benefit.

Signature of principal member ____________ **Date** D D – M M – 2 0 Y Y

For Multiply

1. I, the principal member, hereby apply for membership of Multiply and if applicable on behalf of my dependants, which is administered by MMI Multiply (Pty) Ltd. If MMI Multiply (Pty) Ltd accepts this application, this application will serve as evidence that I agree to be bound by the rules of Multiply and undertake to adhere to such rules at all times. I may obtain a copy of the rules from the Momentum website (www.momentum.co.za/multiply) or the Multiply client contact centre on 0861 100 789.
2. I consent to paying the membership fees (where applicable) in return for the benefits supplied by Multiply to my dependants (where applicable) and me. I understand that it is my sole responsibility to ensure that MMI Multiply (Pty) Ltd receives my membership fees.
3. I acknowledge that MMI Multiply (Pty) Ltd reserves the right to cancel the membership applied for in this form if any of my dependants (who are members of the programme by virtue of this application) or I breach any of the terms and conditions of this agreement, inclusive of rules and regulations pertaining to the Multiply programme which are subject to change from time to time.
4. MMI Multiply (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally.
5. I consent that MMI Multiply (Pty)Ltd ("Mulitiply") may process and retain personal information submitted by me, my financial advisor or the Multiply service provider and that this information may be shared with the Multiply service providers for the purpose of carrying out the actions for Multiply to allocate physical health and wellness points or other benefits to me in terms of my membership. I further consent to the use of my personal information for the purposes of direct marketing of Multiply's own service. I declare that I am aware of my right of access to and the right to rectify the personal information and the existence of a right to object against the processing of personal information. I declare that the personal information provided by me is done voluntary and that failure to provide such information or refusal to consent to the processing of my personal information may result in my membership application not being successful.

For HealthSaver

1. I agree to be bound by the Rules and Conditions that apply to the HealthSaver and the terms and conditions of the loan agreement as set down in the Rules and Conditions.
2. I have been provided with a copy of the Rules and Conditions and I have been given an opportunity to consider, familiarise myself with and agree to the Rules and Conditions.
3. I appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the HealthSaver and for making the relevant payments as per the Rules and Conditions.
4. I acknowledge that:
   i. In doing so, Momentum acts as my agent.
   ii. I assume all risks connected with the administration of the entrusted funds by Momentum, understanding that Momentum is bound by the Financial Institutions (Protection of Funds) Act 28 of 2001.
   iii. I will direct all enquiries in respect of the HealthSaver to Momentum.

   I have read and understand the above clause, have had an opportunity to question and consider it and I agree to the consequences of it.

Section 7: Terms and conditions (continued)

For HealthSaver: Credit granting for application

1. I confirm that the above information is true and complete.
2. I understand that the information provided under the Credit Assessment Inventory will yield a net income figure and that this will determine whether credit will be granted.
3. I understand that the maximum credit I can qualify for is R24 000.
4. I agree that ad-hoc contributions and rebates will not affect the credit advanced to me.
5. I agree that my application is subject to verification, processing and screening and that Momentum may decline an application based on these checks. In addition I give consent that upon acceptance my application will still be subject to continuous screening which may lead to the termination of my application or a reduction in the amount advanced to me when necessary.
6. Momentum reserves the right to share my payment behaviour with various credit bureaus and I understand that this will have an impact on my credit worthiness.
7. I give Momentum the right to, upon the cancellation or termination of the HealthSaver product, offset any debt owing by me to Momentum Health or any Momentum product from funds available in the HealthSaver;
8. I give Momentum the right to, upon the cancellation or termination of the HealthSaver product, hand over my unpaid accounts in respect of the HealthSaver for collection and listing on the credit bureaus.
9. I understand that credit granted will be subject to a variable interest rate.

For AdviceFee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Health.
2. The services that my financial adviser has agreed to render to me include, but are not limited to:
   - handling enquiries in relation to my membership of Momentum Health
   - keeping Momentum Health informed of changes in my membership details
   - informing me of changes in my contributions to Momentum Health, and
   - advising me of changes to the product and benefits that Momentum Health offers.
3. This fee may be reviewed annually when my contributions to Momentum Health are reviewed and increased by a rate based on the average contribution increase to Momentum Health. I will receive reasonable written notice of any such intended change.
4. The agreement will start when I become a member of Momentum Health, unless stated otherwise, and will end when my financial adviser is not entitled to receive compensation for my membership of Momentum Health for any reason whatsoever.
5. I acknowledge that this fee will not form part of my contribution to Momentum Health and will therefore be a separate charge.
6. I instruct MMI Group Ltd to collect the above fee, on the due date, in terms of the payment details given in this application and pay my financial adviser on my behalf.

For HealthWaiver

I accept and understand that I am limiting my right to privacy. However, to enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits under this or any other application for insurance that I have made or that was made for me as the insured life, I authorise the MMI Group Limited, a registered long-term insurer, including the current and future subsidiaries and/or representatives (Momentum):

- to obtain from any person, including Momentum Health and their administrators, any information that Momentum needs in connection with this application or the policy. I also authorise and instruct such person to give the said information to Momentum, and
- to share with other insurers that information and any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

1. This document and any documents that were submitted in connection with it form the basis of the contract I intend entering into, and all information that I have supplied is correct and complete.
2. I undertake to let Momentum know in writing if a change takes place in the health of the insured life/lives between the date of this application and the starting date of the policy or the acceptance date, whichever occurs last.
3. Only the conditions in the contract will bind Momentum and not the representations or undertakings that any person makes or gives.
4. I consent that Momentum may inform anyone who later owns this policy if Momentum adjusts the benefits or the premium under this policy for any reason.
5. I understand that Momentum will cancel the insurance contract that it has issued under this application if the insured life/lives has/have withheld any material information on this application form, or answered any question/s incorrectly, and that the policyholder will forfeit all premiums that he/she paid.
6. I understand that I may cancel this contract within 30 days of the date of the letter of acceptance. I also understand that if I use this right, Momentum will pay back all premiums that I have paid, after Momentum has deducted the cost of any benefits I have enjoyed, the cost of any investment and/or currency risk exposure, and certain expenses.
7. I acknowledge that I have read the valid and official quotation that Momentum has issued that sets out the policy benefits for which I have applied in the properly completed policy application. I confirm that my authorised financial adviser has explained the contents of the quotation to me and I agree that the details set out in it will bind me.

Section 7: Terms and conditions (continued)

For HealthWaiver (continued)

8. I acknowledge and understand that the MMI Group Limited and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain if I sign this application before completing it in full. I acknowledge and understand that it is an offence to sign a blank or incomplete application form, as stated in the Policyholder Protection Rules that have been published under the Longterm Insurance Act 52 of 1998.
9. I am aware that any information provided for the purpose of this application is subject to the stipulations of the Financial Intelligence Centre Act 38 of 2001 and that it will be dealt with in accordance with requirements that the Act contains.
10. I acknowledge that I have read the declaration above, that I fully understand the nature and effect of it and that it will bind me.
11. I accept all legal risks associated with communicating with Momentum via the electronic medium that I chose in this communication, and I indemnify and hold Momentum harmless against any consequent loss that I or any third party may suffer as a result of the misuse, misapplication, or misinterpretation of this communication. In the event of a conflict between the contents of this communication and any subsequent written instruction of the policyholder, this communication will take precedence, and will be binding on the policyholder, provided that this communication has been properly completed and is regular on the face of the document.

Sign here to accept the terms and conditions relevant to the complementary products you are applying for.

Signed at

Signature of principal member **Date** D D – M M – 2 0 Y Y

GapCover

Take care of shortfalls for in-hospital procedures and other healthcare related expenses not covered by your option through Momentum GapCover. Momentum GapCover is underwritten by Guardrisk Insurance Company Limited, a wholly owned subsidiary of MMI Holdings Limited. To apply, please speak to your financial adviser.

Domesticare

With DomestiCare, your domestic worker/s can get quality healthcare cover from private doctors, dentists and optometrists. For more information on DomestiCare, or to complete the quick online registration process, please visit www.domesticare.co.za. Alternatively, you can contact us on 021 673 1800 or 0860 101 159, should you require more information or assistance with the registration process.

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
Call Centre 0860 11 78 59 member@momentumhealth.co.za www.momentumhealth.co.za
Reg. No. 1904/002186/06 Momentum, a division of MMI Group Limited, an authorised financial services and credit provider