Informed Healthcare Solutions (IHS)

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FAX COVER SHEET

To:	Graham Pike of IHS	**From:**	
Fax:	086 627 7012	**Company:**	
Tel:	021 712 6686	**Tel:**	
Pages:		**Date:**	
Re:	Momentum Health Medical Aid Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 086 627 7012 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success

momentum
health

Consolidated Application for membership

Includes Health Saver, Multiply, Advice Fee and Health Waiver

2010

Important notes:
- 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 a copy of ID, for all beneficiaries.
- FICA requirements for Health Saver: Proof of identification and proof of residential address (complete the residential address on this application form).
- If this application is for groups and the company is not already listed on Momentum Health, a company application form needs to be completed as well.
- If this application is for Government employees, attach a copy of your latest payslip.

Section 1: Personal details

Principal member

Title ______ Initials ______ First name ______

Surname ______

Previous surname ______

ID/Passport number* Y Y M M D D ______ Gender: Male ☐ Female ☐
*If passport number, please supply date of birth

Country of residence ______ Marital status ______

Residential address ______

______ Postal code ______

Postal address (if different) ______

______ Postal code ______

Telephone - home (code - number) ______ Cellphone number ______

E-mail address ______

Would you like to receive a Mobicard? Yes ☐ No ☐

What prompted you to join Momentum Health? Financial Adviser ☐ Advertising ☐ Internet ☐ Personal Recommendation ☐

Other, please specify details ______

Spouse or partner

Title ______ Initials ______ First name ______

Surname ______

Previous surname ______

ID/Passport number* Y Y M M D D ______ Gender: Male ☐ Female ☐
*If passport number, please supply date of birth

Country of residence ______ Marital status ______

Dependants

First name	Surname if different to principal member	ID number/ Passport No	Date of birth	Gender (M/F)	Relationship to principal member	Adult over 21 (Yes/No)
1.						
2.						
3.						
4.						
5.						

Are the adult dependants financially dependent on the principal member? Yes ☐ No ☐

Do the dependants receive an income, e.g. pension, salary? Yes ☐ No ☐

If Yes, what is the monthly income?

Adult dependant 1 R ______ Adult dependant 2 R ______

Adult dependant 3 R ______ Adult dependant 4 R ______

Section 2: Employer information

Non-government employees

Company Name

Branch name | Branch number

Existing group number | Employee number

Business telephone number (code - number) | Date of employment D D – M M – Y Y Y Y

Principal member's monthly income

Principal member's occupation

Government employees

Name of department

Persal Number*
*Please attach a copy of your latest payslip | Date of employment D D – M M – Y Y Y Y

Principal member's monthly income

Principal member's occupation

Section 3: Business information if self-employed

Company Name

Registration number | Registration date D D – M M – 2 0 Y Y

Nature of Business

Telephone - work (code - number) | Fax - work (code - number)

Cellphone number | Preferred method of communication: E-mail ☐ Post ☐

E-mail address

Business physical address

Postal code

Business postal address
(if different)

Postal code

Section 4: Financial adviser

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %
				100 %

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

How would you like to receive your welcome pack? Mail to member ☐ Send to branch ☐ Broker to collect ☐

Section 5: Marketing adviser

Name | Marketing adviser's code

Branch name | Telephone - work (code - number)

E-mail address

Section 6: Previous medical scheme information

Please list previous medical scheme membership details for principal member, spouse and adult dependants separately.

Name of member	Name of scheme	Member number	Date joined	Date terminated

Section 6: Previous medical scheme information

Are you changing your medical scheme due to a change in your employment?	Yes	No
Have you, your spouse or any of your dependants ever had a waiting period, pre-existing condition exclusions or a late joiner penalty? If Yes, please attach previous membership certificate (if available).	Yes	No

Section 7: Medical details

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

Complete Section 7.1 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 7.2.

Please make sure that you have completed Section 6 before completing this section

Have you or your dependants ever had any of the following:

SECTION 7.1

7.1.1	Have you or your dependants ever suffered from diabetes, heart disease, stroke or cancer?	Yes	No
7.1.2	Have you or your dependants had an operation or admission to any hospital in the last 12 months?	Yes	No
7.1.3	Are you or your dependants awaiting or planning any operation or admission to hospital (including pregnancy) for treatment in the next 12 months?	Yes	No
7.1.4.	Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication in the next 12 months?	Yes	No
7.1.5	Is there any other condition or symptom, which is not detailed in any question above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months?	Yes	No

If you have answered **no** to **all** of the above questions, we will not apply any waiting periods and you do not have to complete Section 7.2.

If you have answered **yes** to **any** of the above questions, we will apply a three-month general waiting period to all dependants included on your application form and you do not have to complete Section 7.2.

SECTION 7.2

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

Have you or your dependants ever had any of the following: If yes to any of the questions please provide full details, should require addition space please add an additional page to the application form.

7.2.1 **Disorders or problems with the heart or cardiovascular system**. Eg. 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

7.2.2 **Respiratory or lung trouble.** Eg 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

7.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas of liver**. Eg 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

7.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs**. Eg 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

7.2.5 **Disorders of the nervous system or brain**. Eg epilepsy , stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's diseae, 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

Section 7: Medical details (continued)

7.2.6 **Mental disorders.** Eg depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, or post traumatic stress disorder?

Yes ☐ No ☐

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

7.2.7 **Ear, nose, throat or eye disorders.** Eg 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

7.2.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs, spine.** Eg 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

7.2.9 **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

7.2.10 **Cancer**, a growth or tumour of any kind including moles removed (malignant/benign)?

Yes ☐ No ☐

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

7.2.11 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

7.2.12 Have you had any accidents (including motor vehicle accidents) in the past 24 months? If yes, please provide details of injuries sustained?

Yes ☐ No ☐

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

7.2.13 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

7.2.14 Have you or any of your dependants had any surgical procedure in the past 24 months?

Yes ☐ No ☐

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

7.2.15 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, or 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

Section 7: Medical details (continued)

Questions 7.2.16 to 7.2.18 apply to female applicants

7.2.16 Disorders of the female organs. Eg endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormality of pregnancy or confinement? Yes [ ] No [ ]

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

7.2.17 Are you currently pregnant? Yes [ ] No [ ]

7.2.18 Do you have regular Pap smears or mammograms? If yes please give details of your most recent results? Yes [ ] No [ ]

Name of member	Date of pap smear	Result

If you or any of dependants are living with HIV/Aids and would prefer not to disclose your or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number. On receipt of your membership number please call us at 0860 50 60 80, in order to notify us that you or your dependants are living with HIV/Aids. This information will be kept confidential. Please advise us within 7 days of your date of entry onto Momentum Health, failing which membership may be terminated for non-disclosure.

7.2.19 **Principal member**

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

Spouse or partner

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

Adult dependant 1

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

Adult dependant 2

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

Adult dependant 3

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

Adult dependant 4

Height (without shoes) [ ] , [ ] [ ] m Tobacco smoked: Type [ ] Quantity per day [ ]

Mass (clothed) [ ] [ ] [ ] kg Alcohol consumed: Type [ ] Quantity per week [ ]

7.2.20 Have you taken out a life insurance policy with Momentum during the last six months? Yes [ ] No [ ]

If Yes please supply your policy number. [ ]

Current doctor

Name and surname [ ]

Telephone - work (code - number) [ ] How long has he/she been your doctor? [ ]

Current dentist

Name and surname [ ]

Telephone - work (code - number) [ ] How long has he/she been your dentist? [ ]

Section 8: Option choice

Important note: The principal member may make changes only on 1 January each year.

Base Option ☐

Hospital provider	Chronic and Day-to-day provider	Salary
Base Network ☐	CareCross ☐	R7 501 or more ☐
State ☐	Faranani ☐	R5 501 - R7 500* ☐
	Prime Cure ☐	R3 501 - R5 500* ☐
		Less than R3 500* ☐

Provider's practice number

Provider's practice name

* If less than R7 500, please attach a copy of your payslip

Access Option ☐

Hospital provider: Access Network

Chronic and Day-to-day provider

- Medicross ☐
- Prime Cure ☐

Provider's practice number

Provider's practice name

Custom Option ☐

Hospital provider	Chronic and Day-to-day provider	Savings:7.5%
Any hospital ☐	Any ☐	
Associated hospitals ☐	Associated GP and Courier Pharmacies ☐	
	State ☐	

Incentive Option ☐

Hospital provider	Chronic and Day-to-day provider	Savings:10%
Any hospital ☐	Any ☐	
Associated hospitals ☐	Associated GP and Courier Pharmacies ☐	
	State ☐	

Extender Option ☐

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

Section 9: Banking details for payment of contributions

(Momentum Health does not debit from credit card accounts)

Is the contribution payer the:

- Principal Member (complete only section 9.2) ☐
- Company (as per company application form – ignore sections 9.1 and 9.2) ☐
- Other (complete sections 9.1 and 9.2) ☐

Section 9.1

Title ____ Initials ____ First name ____

Surname/Company name ____

RSA ID Yes ☐ No ☐ Gender: Male ☐ Female ☐

ID/Passport number* Y Y M M D D

*If passport number, please supply date of birth

Section 9.1 (continued)

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number)

Cellphone number

E-mail address

Section 9.2

Name of account holder

Name of institution

Account number

Account type: Current Savings Transmission

Deduction day 0 1

Branch code

Branch name

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. I / we agree to inform Momentum Health in writing of any changes that take place. I / we authorise Momentum Health to verify such account details with the financial institution. We accept that Momentum Health may debit the account on a date other than specified.

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.

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D – M M – **2 0** Y Y

Section 10: Banking details for claim refunds payable to member

Name of account holder

Name of institution

Account number

Account type: Current Savings Transmission

Branch code

Branch name

Signature of principal member

Date D D – M M – **2 0** Y Y

Section 11: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by Momentum Medical Scheme Administrators (MMSA) (the 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, it will make any contracts to which this application relates null and void. I will also forfeit all contributions that I paid to the Scheme. In such an event the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on behalf of me or my dependants under such contracts.

3. I will notify the Scheme if any alteration takes place in any circumstances on which the Scheme based its assessment of its risk after the date of this application and before the date of the Scheme's acceptance of the risk. I acknowledge that failure to do so will make any contracts to which this application relates null and void. 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 contracts.

4. I understand that this application form is valid for 30 days only

5. I am aware that the Scheme may ask for proof of identification at any stage.

6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contribution.
   - Non-receipt of a single month's contribution will result in suspension of medical scheme benefits. This suspension will last until I have paid all contributions in arrears.
   - Non-receipt of two months' contributions will result in cancellation of my membership of the Scheme.

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.

9. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Scheme, my answers on this form will form the basis of my membership.

10. 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 has existed on my admission date.

11. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.

12. In the case of new members of the Scheme, the following may apply:
   - A three-month general waiting period;
   - A twelve-month exclusion on a pre-existing condition; and/or
   - Late-joiner contribution penalty.

13. I will notify the Scheme if I or any of my dependants are living with HIV/Aids.

14. 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.

15. I understand that if I have selected the Base or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.

16. 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.

17. Words used in this application have the meaning that the Rules give them.

18. 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.

19. I acknowledge that my 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.

Should Momentum Health confirm your starting date before acceptance?	Yes ☐ No ☐
Should Momentum Health confirm your terms of acceptance?	Yes ☐ No ☐
Starting date	0 1 – M M – 2 0 Y Y
Signed at	
Signature of principal member	**Date** D D – M M – 2 0 Y Y

momentum

Annexure for complementary products

2010

Important notes:
- Momentum Health members may add any of these complementary products.
- You need to complete the contract details for each product required.
- We will use the personal details completed for Momentum Health for this contract
- FICA requirements for Health Saver: Proof of identification and proof of residential address

Product Selection:
Please indicate which Complementary products you are applying for, and complete relevant sections

Health Saver	Yes	No
Multiply	Yes	No
Advice Fee	Yes	No
Health Waiver	Yes	No

Section 1: FICA declaration

I confirm that I have identified the client, including the investor and contribution payer, where applicable, and verified his/her/their details on this contract under the requirements that section 21 of the Financial Intelligence Centre Act, No 38 of 2001, sets out. I further confirm that in terms of section 22 of the same Act (effective from 1 July 2003) I have stored all the verification documents.

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

Source of funds and source of income

Remuneration/salary as employee	Name of employer
Remuneration as owner/entrepreneur	Name of main business
	Nature of business
Inheritance	Name of trust/estate late
Investment income	Source of capital
Winnings	Source, eg Lotto, dated D D – M M – Y Y Y Y
Other	Name of main business

Section 2: Health Saver contract details

Starting date: Same as Momentum Health | Automatic starting date *

* Automatic starting date: The starting date will be the first of the month following the acceptance of the contract.

Do you require credit Yes No

If credit was selected, please complete:

Monthly amount R

and/or upfront single amount R

If no credit was selected, please complete:

Monthly amount R

and/or upfront single amount R

Please note that the Health Saver amount is subject to monthly adminstration fees and the credit amount to a variable interest rate.

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:	Momentum Group Limited
Physical Address:	268 West Avenue Centurion Gauteng 0157
Contact number	0860 11 78 59 Weekdays 08:00 to 17:00

Section 2: Health Saver contract details (continued)

Credit assessment inventory

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

Section 3: Multiply Contract details

Contributions will be calculated based on the membership composition of Momentum Health:

- Single member
- Family of two
- Family of three or more

How would you like to receive your welcome pack?

Mail ☐ Client collect ☐ Branch ☐ Broker collect ☐

Starting date: Same as Momentum Health x

Name of previous lifestyle programme

Previous lifestyle programme status (Please provide proof of status with the most recent statement not older than 1 month)

Section 4: Advice Fee Contract details

Please select one of the following Advice Fee options:

Negotiated amount ☐ Per month ☐ or Single annual deduction ☐

Per member ☐ or Per group/employer ☐

or

Fixed monthly amount R 50.00 ☐ R 65.00 ☐ R 80.00 ☐ Increase option Annual review ☐ None ☐

Per month ☐ or Single annual deduction ☐

Starting date Same as Momentum Health ☐ Automatic starting date * ☐

* Automatic starting date: The starting date will be the first of the month following the acceptance of the contract.

Section 5: Health Waiver

Section 5.1 Insured life/lives

Insured life/lives: Principal member ☐ Spouse ☐

Section 5.2 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 ☐

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 ☐

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 ☐

Section 5: Health Waiver (continued)

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 Momentum Health membership or adds new dependants (except as a result of marriage or child birth) to his Momentum Health membership, a new 3-year period will apply to the increase in the Momentum Health contribution from the date of the increase.

Signature of principal member		**Date**	DD – MM – 20YY
Signature of spouse		**Date**	DD – MM – 20YY

Section 5.3 Start of policy

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

Automatic starting date*	x

*The starting date will be the first day of the month following the acceptance of the benefits.

Section 5.4 Replacement of insurance

Do any benefits under this policy replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance that you discontinued within the past four months or that you will discontinue within the next four months)? Yes ☐ No ☐

If Yes, the financial adviser must discuss the facts and implications with the applicant, then fill in the Replacement Policy Advice Record - MOM 681 - and attach it to this application form. Replacement of any insurance is generally to the disadvantage of the applicant because it involves duplication of the initial costs charged to the policy.

Section 5.5 Policy Holder details

Name of legal entity			
Contact person in case of legal entity			
Registration number		Registration date	DD – MM – 20YY
Postal address			
		Postal code	
Telephone - work (code - number)		Fax - work (code - number)	
Cellphone number		Correspondence language:	English ☐ Afrikaans ☐
E-mail address		Preferred method of communication:	E-mail ☐ Post ☐
Tax status:	Company / Close Corporation (M) ☐	Natural persons (N) ☐	Nontaxable Institution(I) ☐
Tax status of trust beneficiaries if the applicant is a trust company	Company (C) ☐	Natural persons (P) ☐	Nontaxable Institution(Z) ☐

Section 6: Contribution payer information

If different account details required per complementary product, please make a copy of the annexure and attach to this application form

Is the contribution payer the:

Principal Member (complete only section 6.2)	☐
Company (as per company application form – ignore sections 6.1 and 6.2)	☐
Other (complete sections 6.1 and 6.2)	☐

Section 6.1

Title		Initials	First name
Surname /Name of company			
ID/Passport number	YYMMDD	Gender:	Male ☐ Female ☐
RSA ID	Yes ☐ No ☐	Date of Birth	YYYYMMDD
Residential address			
		Postal code	
Postal address (if different)			
		Postal code	
Telephone - home (code - number)		Cellphone number	
E-mail address			

Section 6: Contribution payer information (continued)

Section 6.2

(Momentum does not collect from credit card accounts)

Name of account holder

Name of institution

Account number

Account type: Current Savings Transmission Deduction date

Branch code Branch name

Should Momentum group* all collections from this account number and deduct them from your account as one amount? Yes No

* Note: Although Momentum will take great care to always group collections, the grouping can not be guaranteed. The grouping does not include the Momentum Health contribution.

Section 7: Details for contribution collection

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 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 D D – M M – 2 0 Y Y

Section 8: Terms and conditions

For Health Saver

1. I, the undersigned (the "Investor"), agree to be bound by the rules and conditions applicable to the Health Saver and the terms and conditions of the Loan Agreement as set out in the Rules and Conditions.
2. I hereby appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the Health Saver with FNB Corporate, and I:
   - Confirm that, in doing so, Momentum acts as my agent;
   - Assume, except insofar as there may be a right of recovery against Momentum, all risks connected with the administration of the entrusted funds by Momentum, as well as the responsibility to ensure that Momentum executes the instruction as recorded herein;
   - Agree that I shall direct all enquiries and instructions in respect of the Health Saver to Momentum.

Credit granting for applications

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 R18 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 when necessary.
6. I understand that credit granted will be subjected to a monthly administration fee and a variable interest rate.

For save thru spend

1. I understand that this application to a participating Momentum company entitles me to participate in the save thru spend programme administered by Momentum Interactive (Pty) Ltd, a wholly owned subsidiary of Momentum Group Limited, whereby participants become entitled to certain benefits for transactions that such participants enter into with selected save thru spend partners. A list of save thru apend partners is available from Momentum Interactive (Pty) Ltd on request.
2. I understand that a set of rules issued by Momentum Interactive (Pty) Ltd governs my right to participate in save thru spend and its benefits. On acceptance by Momentum of this application I will receive a temporary card together with a brochure indicating which suppliers participate in save thru spend. Future updates of the rules and benefits, as well as the suppliers, are available from the Momentum website (www.momentum.co.za) or I may obtain these from the save thru spend client call centre at 0860 728 348.
3. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 2 above and may vary the benefits of save thru spend unilaterally from time to time by providing prior written notice to participants. I understand that I may cancel my participation from this programme if I do not wish to accept the amended rules or benefits.
4. I consent to the recording of all conversations between Momentum Interactive (Pty) Ltd and/or its representatives and me, and that all information that Momentum Interactive (Pty) Ltd obtains through these conversations will form part of its records. I further consent to all of these recordings remaining the sole property of Momentum Interactive (Pty) Ltd.

Section 8: Terms and conditions (continued)

5. I consent to Momentum Interactive (Pty) Ltd disclosing to any third party any information that I or any other entity supplied to Momentum Interactive (Pty) Ltd by virtue of my participation in save thru spend, provided that the party to which Momentum discloses such information agrees to keep it confidential at all times.

6. Momentum Interactive (Pty) Ltd reserves the right to cancel this agreement if it finds that the information that I have supplied is incorrect and/or false.

7. I acknowledge and understand that any tax liability that the Momentum Group or any of its subsidiaries may incur may reduce my save thru spend benefits.

8. This application form was duly and fully completed before I signed it and the information contained herein is true and correct. I shall not cede any of my rights in terms of this agreement.

9. I acknowledge and understand that the Momentum Group and/or Momentum Interactive and/or their subsidiaries, agents and authorised representatives will not be responsible for any loss or damage arising from any cause, including but not limited to changes in tax or other legislation or the interpretation of these, which I may sustain as a result of me receiving the save thru spend benefit. Furthermore, I indemnify Momentum Group Limited, Momentum Interactive (Pty) Ltd and/or any of their employees and hold them harmless against any claim of any nature arising directly or indirectly from my and/or my dependants' participation in save thru spend.

10. I understand that
    - My participation in save thru spend entails that it is my responsibility to identify myself by showing my save thru spend card and/or registering my save thru spend number when transacting with a save thru spend partner in order to receive benefits, and that no benefits will result unless I do so; and
    - I have to keep detailed records of any transactions that I conclude with any of the save thru spend partners and that if I do not inform Momentum Interactive (Pty) Ltd within 60 days of any discrepancies that may exist between my records and those of Momentum Interactive (Pty) Ltd, I will forfeit any benefit to which I may become entitled in terms of these records.

11. The right to participate in save thru spend and its benefits is a standard benefit that the Momentum Group provides to all investors in certain of Momentum's products. No other persons are eligible to participate. While I receive the right to participate, I am not obliged to do so. My failure to do so will mean that no benefit will accrue to me on any product with a Momentum participating company.

12. Momentum Interactive (Pty) Ltd may decide at its sole discretion from time to time who may participate in the save thru spend programme.

13. I acknowledge that I will only become entitled to the save thru spend benefit from a transaction once the save thru spend partner with whom I have transacted accepts and settles its liability to Momentum Interactive (Pty) Ltd for the transaction in full. The Momentum participating company will then apply the benefit to the product concerned.

14. The *contra proferentem* rule (i.e. the rule that causes the wording to be construed against the party who drafted the wording in cases of doubt) shall not apply in the interpretation of the terms and conditions.

For Multiply

1. I, the principal member, hereby apply for my dependants (where applicable) and me to become members of Multiply, which is administered by Momentum Interactive (Pty) Ltd. If Momentum Interactive (Pty) Ltd accepts this application then 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) or the Multiply client contact centre at 0861 88 66 00.

2. I consent to paying the monthly contributions in return for the benefits supplied by Multiply to my dependants (where applicable) and myself. I understand that it is my sole responsibility to ensure that my monthly contributions are received by Momentum Interactive (Pty) Ltd.

3. I acknowledge that Momentum Interactive (Pty) Ltd reserves and shall have the right to cancel the membership applied for herein if I or any of my dependants (that are members of the programme by virtue of this application) breach any of the terms and conditions of this agreement inclusive of rules and regulations pertaining to the Multiply programme in force from time to time.

4. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally from time to time, but shall inform members of any such amendments. I understand that I may cancel my participation on Multiply at any time, including when I do not accept the amended rules and benefits.

For Advice Fee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Health Medical Scheme (Momentum Health), for a monthly fee per principal member as provided for in regulation 28(6)(b) of the Medical Schemes Act. These amounts include VAT, if applicable.

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 Momentum 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.

Section 8: Terms and conditions (continued)

For Health Waiver

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 Momentum 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 Statutory Notice and I confirm that my authorised financial adviser has explained its legal nature and contents to me.
8. 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.
9. I acknowledge and understand that the Momentum 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 Long-term Insurance Act of 1998.
10. I am aware that any information provided for the purpose of this application is subject to the stipulations of the Financial Intelligence Centre Act No 38 of 2001 and that it will be dealt with in accordance with requirements that the Act contains.
11. 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.
12. 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.
13. I consent that if the policyholder dies and there is still an in-force benefit on this policy, the insured life under such a benefit will become the policyholder of this policy.

Signed at

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