



Informed Healthcare Solutions (IHS)

119 Main Road
Heathfield
Cape Town

Tel: +27 21 712-8866
Fax: 0866 200 320
Email: info@medicalaidcomparisons.co.za
Web: www.medicalaidcomparisons.co.za

FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	0866 200 320	Company:	
Tel:	021 712 8866	Tel:	
Pages:		Date:	
Re:	Momentum Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 0866 200 320 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

Individual Application for membership

Includes HealthSaver, Multiply, AdviceFee and HealthWaiver

2012

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 principal member, spouse and adult dependants.
- FICA requirements for HealthSaver: Certified proof of identification and proof of residential address (not older than 3 months)
- If this application is for groups and the company is not already listed on Momentum Health, a company application form needs to be completed.
- If this application is for Government employees, attach a copy of your latest payslip.

Section 1: Personal details

Principal member

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>				
Previous surname	<input type="text"/>				
ID/Passport number*	<input type="text"/>	Gender:	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>*If passport number, please supply date of birth</small>	<input type="text"/>				
Country in which passport was issued	<input type="text"/>				
Country of residence	<input type="text"/>	Marital status	<input type="text"/>	<input type="text"/>	<input type="text"/>
Residential address	<input type="text"/>				
	<input type="text"/>	Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address (if different)	<input type="text"/>				
	<input type="text"/>	Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone - home (code - number)	<input type="text"/>	Cellphone number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>				

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	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>				
Previous surname	<input type="text"/>				
ID/Passport number*	<input type="text"/>	Gender:	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>*If passport number, please supply date of birth</small>	<input type="text"/>				
Country in which passport was issued	<input type="text"/>				
Country of residence	<input type="text"/>	Marital status	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone - home (code - number)	<input type="text"/>	Cellphone number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>				

Dependants (If dependants are also applying for membership)

Dependant 1

First name	<input type="text"/>														
Surname	<input type="text"/>														
ID/Passport number*	<input type="text"/>	Gender:	<input type="text"/>	<input type="text"/>	<input type="text"/>										
<small>*If passport number, please supply date of birth</small>	<input type="text"/>														
Country in which passport was issued	<input type="text"/>														
Date of birth	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	Cellphone number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>														
Relationship to principal member	<input type="text"/>														
Is the dependant financially dependent on principal member?											Yes	<input type="text"/>	No	<input type="text"/>	
Dependant's monthly income	R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Dependant 2

First name	<input type="text"/>																											
Surname	<input type="text"/>																											
ID/Passport number* <small>*If passport number, please supply date of birth</small>	<input type="text"/>										Gender:		<input type="text"/>					<input type="text"/>										
Country in which passport was issued	<input type="text"/>																											
Date of birth	<input type="text"/>		-		<input type="text"/>		-		<input type="text"/>				Cellphone number												<input type="text"/>			
Email address	<input type="text"/>																											
Relationship to principal member	<input type="text"/>																											
Is the dependant financially dependent on principal member?																									<input type="text"/>		<input type="text"/>	
Dependant's monthly income	R	<input type="text"/>																										

Dependant 3

First name	<input type="text"/>																											
Surname	<input type="text"/>																											
ID/Passport number* <small>*If passport number, please supply date of birth</small>	<input type="text"/>										Gender:		<input type="text"/>					<input type="text"/>										
Country in which passport was issued	<input type="text"/>																											
Date of birth	<input type="text"/>		-		<input type="text"/>		-		<input type="text"/>				Cellphone number												<input type="text"/>			
Email address	<input type="text"/>																											
Relationship to principal member	<input type="text"/>																											
Is the dependant financially dependent on principal member?																									<input type="text"/>		<input type="text"/>	
Dependant's monthly income	R	<input type="text"/>																										

Dependant 4

First name	<input type="text"/>																											
Surname	<input type="text"/>																											
ID/Passport number* <small>*If passport number, please supply date of birth</small>	<input type="text"/>										Gender:		<input type="text"/>					<input type="text"/>										
Country in which passport was issued	<input type="text"/>																											
Date of birth	<input type="text"/>		-		<input type="text"/>		-		<input type="text"/>				Cellphone number												<input type="text"/>			
Email address	<input type="text"/>																											
Relationship to principal member	<input type="text"/>																											
Is the dependant financially dependent on principal member?																									<input type="text"/>		<input type="text"/>	
Dependant's monthly income	R	<input type="text"/>																										

Section 2: Employer information**Non-government employees**

Company Name	<input type="text"/>																									
Branch name	<input type="text"/>										Branch number					<input type="text"/>										
Existing group number	<input type="text"/>										Employee number					<input type="text"/>										
Business telephone number (code - number)	<input type="text"/>										Date of employment					<input type="text"/>										
Principal member's monthly income	<input type="text"/>																									
Principal member's occupation	<input type="text"/>																									

Section 2: Employer information

Government employees

Name of department	<input type="text"/>																				
Persal Number*	<input type="text"/>										Date of employment	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Please attach a copy of your latest payslip																					
Principal member's monthly income	<input type="text"/>																				
Principal member's occupation	<input type="text"/>																				

Section 3: Business information if self-employed

Company Name	<input type="text"/>																				
Registration number	<input type="text"/>										Registration date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nature of Business	<input type="text"/>																				
Telephone - work (code - number)	<input type="text"/>										Fax - work (code - number)	<input type="text"/>									
Cellphone number	<input type="text"/>										Preferred method of communication:	<input type="checkbox"/> Email					<input type="checkbox"/> Post				
Email address	<input type="text"/>																				
Business physical address	<input type="text"/>																				
	<input type="text"/>															Postal code	<input type="text"/>				
Business postal address (if different)	<input type="text"/>																				
	<input type="text"/>															Postal code	<input type="text"/>				

Section 4: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %
Graham Pike		031944		100 %

Signature of financial adviser	<input type="text"/>										Date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How would you like to receive your welcome pack?	Mail to member <input type="checkbox"/>										Send to branch <input type="checkbox"/>					Other (please specify) _____					

Section 5: Marketing adviser (where applicable)

Name	<input type="text"/>										Marketing adviser's code	<input type="text"/>								
Branch name	<input type="text"/>					Telephone - work (code - number)	<input type="text"/>													
E-mail address	<input type="text"/>																			

Section 6: 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 every member applying. If more space is required, please include additional pages.

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

Are the details completed above the same for all dependants applying for cover?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If no, please provide details in the space above.				
Are you changing your medical scheme due to a change in your employment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Section 7: Medical details (continued)

SECTION 7.2

Complete Section 7.2 if you have not been a member of a medical scheme registered in South Africa for more than 90 days.

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.

Have you or your dependants had any of the following:

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 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

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

Section 8: Option choice

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

Ingwe Option	Hospital provider	Chronic and Day-to-day provider	Salary
	Ingwe Network	CareCross	R8 400 or more
	State	Prime Cure	R6 301 - R8 400*
			R3 951 - R6 300
			Less than R3 950
Provider's practice number			* If less than R8 400, please provide proof of your household income
Provider's practice name			

Access Option	Hospital provider: Access Network	Chronic and Day-to-day provider
		CareCross
		Medicross
		Prime Cure
Provider's practice number		
Provider's practice name		

Custom Option	Hospital provider	Chronic and Day-to-day provider
	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
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Section 9: Banking details for payment of contributions

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

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 /Name of company		
ID/Passport number	Gender: Male	Female
RSA ID	Yes	No
	Date of Birth	

Section 9.1 (continued)

Residential address	<input type="text"/>	<input type="text"/>	Postal code	<input type="text"/>
Postal address (if different)	<input type="text"/>	<input type="text"/>	Postal code	<input type="text"/>
Telephone - home (code - number)	<input type="text"/>	Cellphone number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>			

Section 9.2

Name of account holder	<input type="text"/>			
Name of institution	<input type="text"/>			
Account number	<input type="text"/>			
Account type:	<input type="text"/> Current	<input type="text"/> Savings	<input type="text"/> Transmission	
Branch code	<input type="text"/>	Branch name	<input type="text"/>	

Section 10: 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. 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 will debit the account on the 1st of each month or the closest working day after the 1st.

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	<input type="text"/>
Position in company	<input type="text"/>

Signature of account holder/ Authorised signatory	<input type="text"/>	Date	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
Company Stamp	<input type="text"/>		

Section 11: Banking details for claim refunds payable to member

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

Name of account holder	<input type="text"/>			
Name of institution	<input type="text"/>			
Account number	<input type="text"/>			
Account type:	<input type="text"/> Current	<input type="text"/> Savings	<input type="text"/> Transmission	
Branch code	<input type="text"/>	Branch name	<input type="text"/>	

Signature of principal member	<input type="text"/>	Date	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
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Section 12: 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.

Section 12: Terms and conditions (continued)

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. Failure to pay any debt due to the Scheme may result in suspension of membership and/or handover to a third party for debt collection.
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, I 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 (see section 7, on page 4).
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 undertake to give 30 days notice should I wish to terminate my membership.
16. I understand that if I have selected the Ingwe or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.
17. 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.
18. Words used in this application have the meaning that the Rules give them.
19. 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.
20. 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 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 - -

Signature of principal member

Date - -

The HealthSaver is a free product available to all Momentum Health members. We need your consent to activate your HealthSaver account. (See page 10)

Annexure for complementary products

2012

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 HealthSaver: Certified proof of identification and proof of residential address (not older than 3 months)

Product Selection:

Please indicate which Complementary products you are applying for, complete relevant sections and sign page 14.

HealthSaver

Multiply

AdviceFee

HealthWaiver

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 - -

Section 2: HealthSaver contract details

Section 2.1: Free HealthSaver account

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

You can use this account as you see fit to make provision for additional healthcare expenses
If you do not wish to start contributing to HealthSaver at this point, complete Section 2.1 and Section 8.

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 the same account that Momentum Health uses to refund your claims).

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 2.4: 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: Momentum Group Limited

Physical Address: 268 West Avenue
Centurion
Gauteng
0157

Contact number: 0860 11 78 59
Weekdays 08:00 to 17:00

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

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: AdviceFee Contract details

You do not need to complete this section if your employer pays your AdviceFee on your behalf, as the AdviceFee will be determined by the employer.

Please select one of the following AdviceFee options:

Standard monthly amount R 35.00 R 58.00 R 75.00 R 90.00 Increase option Annual Increase

Section 5: HealthWaiver

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?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y Y M M <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Spouse: Yes No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y Y M M <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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.

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 Momentum Health Membership or add new dependents (except as a result of marriage, childbirth or adoption) to my Momentum Health Membership, a new three year period will apply to the increase in my Momentum Health 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	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of spouse	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Section 7: 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 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

- -

Section 8: Terms and conditions

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 with FNB Corporate.
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. It is my responsibility to ensure that Momentum executes the instruction provided in this document, except where there may be a right of recovery against Momentum
 - 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.

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 R18 000.
4. I agree that ad-hoc contribution as 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 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.

Section 8: Terms and conditions (continued)

For AdviceFee

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.

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 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 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.
8. 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.
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 No 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.

Signed at	<input type="text"/>
Signature of principal member	<input type="text"/>
Date	<input type="text" value="DD"/> <input type="text" value="DD"/> - <input type="text" value="MM"/> <input type="text" value="MM"/> - <input type="text" value="20"/> <input type="text" value="YY"/> <input type="text" value="YY"/>