Informed Healthcare Solutions (IHS)

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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

momentum
health

Individual application for membership

2019

Important notes:

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

Section 1: Personal details

Principal member

Title | Initials | First name

Surname

Previous surname | Gender: Male / Female

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

Country in which passport was issued

Country of residence

Income tax reference number* | * Please provide proof of Income tax reference number.

Marital status: Single / Married / Separated / Divorced / Widowed

Home address

Postal code

Postal address (if different)

Postal code

Telephone - home | Cellphone number

Email address

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

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

Title | Initials | First name

Surname

Previous surname | Gender: Male / Female

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

Country in which passport was issued

Country of residence

Telephone - home | Cellphone number

Email address

Section 1: Personal details (continued)

Dependants (If dependants are also applying for membership)

Dependant 1

First name

Surname

ID/Passport number | Gender | Male | Female

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

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

Dependant 2

First name

Surname

ID/Passport number | Gender | Male | Female

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

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

Dependant 3

First name

Surname

ID/Passport number | Gender | Male | Female

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

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

Dependant 4

First name

Surname

ID/Passport number | Gender | Male | Female

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

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

Section 2: Employer information

Section 2.1: Non-government employees

Company name

Branch name

Existing group number

Employee number

Business telephone number

Date of employment D D – M M – Y Y Y Y

Section 2.2: Government employees

Name of department

Persal number *

Date of employment D D – M M – Y Y Y Y

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

Section 3: Business information if self-employed

Company name

Registration number

Registration date D D – M M – Y Y Y Y

Nature of business

Telephone - work

Fax number

Cellphone number

Preferred method of communication E-mail Post

Email address

Business physical address

Postal code

Business postal address (if different)

Postal code

Section 4: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no
Graham Pike	660117	031944	

Signature of financial adviser

Date D D – M M – 2 0 Y Y

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

*If branch is selected, please complete your internal branch code.

Section 5: Previous medical scheme information

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

Please provide certificates of membership for previous schemes.

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

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

If no, please provide details in the space above.

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

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

Section 6: Medical details

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

Principal member

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Spouse or partner

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 1

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 2

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 3

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 4

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Doctor/s consulted in the past 12 months

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

Name and surname

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

Name and surname

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

Name and surname

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

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

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

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

Section 6: Medical details (continued)

Section 6.1

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

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

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

6.1.1 Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months? Yes ☐ No ☐

6.1.2 Have you or your dependants had an operation or admission to any hospital in the last 12 months? Yes ☐ No ☐

6.1.3 Are you or your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months? Yes ☐ No ☐

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

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

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

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

Section 6.2

Complete Section 6.2 if:

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

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

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

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

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

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

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

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

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

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

Section 6: Medical details (continued)

Section 6.2 (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 6: Medical details (continued)

Section 6.2 (continued)

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

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

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

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

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

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

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

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

Questions 6.2.17 to 6.2.18 apply to female applicants

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

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

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

Section 7: Option choice

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

Ingwe Option ☐

Hospital provider	Chronic and Day-to-day provider	
State hospitals	Ingwe Primary Care Network provider	☐
Ingwe Network	Ingwe Primary Care Network provider	☐
Any hospital	Ingwe Active Primary Care Network provider	☐

Income	
R12 501 +	☐
R9 001 - R12 500	☐
R6 801 - R9 000	☐
R701 - R6 800	☐
≤ R700	☐

*If less than R12 501, please complete the **Declaration of Income**

GP's practice number

GP's name

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

Impact Option ☐

Hospital provider	Chronic and Day-to-day provider
Impact Network	Impact Primary Care Network

GP's practice number

GP's name

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

Section 7: Option choice (continued)

Custom Option	**Hospital provider**	**Chronic provider**	
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	
Incentive Option	**Hospital provider**	**Chronic provider**	**Savings: 10%**
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	
Extender Option	**Hospital provider**	**Chronic provider**	**Savings: 25%**
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	
Pay day-to-day claims at:	Accumulation rate	Up to 200% of the Momentum Health Rate	
Summit Option	**Hospital provider**	**Chronic and Day-to-day provider**	
	Any hospital	Freedom-of-choice	

Section 8: Banking details for payment of contributions

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

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

Name of account holder

Name of bank

Account number

Account type Current/Cheque Savings Transmission

Branch code - - - Branch name

Section 9: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

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

If an **individual's** account is to be debited, please sign below:

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

Signature of account holder

Date D D – M M – **2 0** Y Y

Section 9: Authorisation for contribution collection (continued)

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

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

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

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D – M M – 2 0 Y Y

Company stamp

Section 10: Banking details for claim refunds payable to member

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

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

If not, please complete the bank details below.

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

Name of account holder

Name of bank

Account number

Account type ☐ Current/Cheque ☐ Savings ☐ Transmission

Branch code - - - Branch name

Signature of principal member

Date D D – M M – 2 0 Y Y

Section 11: Consent for Momentum Health to process personal information

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Momentum Health.

Momentum Health and the Administrator, MMI Health, a division of MMI Group Limited, will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Momentum Health will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to Momentum Health and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Momentum Health membership risk profiling and management, administration of my membership and as set out in this section.
2. If I have consented to the disclosure of my personal information, Momentum Health or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Momentum Health or the Administrator which requires them to do so.
3. I acknowledge that I must give Momentum Health and the Administrator all information and evidence they may require from time to time. I authorise Momentum Health and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Momentum Health may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of Momentum Health and risk profiling or management. I consent to that person providing, and instruct that person to provide, Momentum Health and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.

Section 11: Consent for Momentum Health to process personal information (continued)

5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
6. I have the right to request my personal information which is in the possession of Momentum Health and the Administrator, provided that I furnish adequate identification.
7. I have the right to request Momentum Health and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
9. My personal information will be shared between Momentum Health, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to my membership of Momentum Health, and
    - to grant me access to interact with Momentum Health on its website; and
    - to provide any credit bureau or registered credit provider with your credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
10. I agree that Momentum Health's Administrator, MMI Health, may use my information for the purpose of marketing (including direct marketing) of insurance, investments, health insurance, retirement benefits, other financial services and health related products offered by MMI and its subsidiaries. Tick here if you do not wish to receive any direct marketing. ☐

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

Section 12: Terms and conditions

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

    I also authorise and instruct any person (such as my employer, a pension fund or provident fund) who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in the first sentence of this clause to the Scheme as and when it is due. Furthermore, I understand that I will be liable for any legal costs that may be incurred by any party in the recovery of any amount that I owe to the Scheme.
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection. Refer to point 6.
9. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that existed for a period of up to twelve (12) months prior to my application to join the Scheme.
10. I acknowledge that the Scheme has the right to apply a three-month general waiting period, a twelve-month exclusion on a pre-existing condition, and/or Late-joiner contribution penalty, where applicable.
11. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 6, on pg 4).
12. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.
13. I undertake to give a calendar month's notice should I wish to terminate my membership.
14. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and / or Administrator against any claim which may arise as a result of my failure to do so.

Section 12: Terms and conditions (continued)

15. Words used in this application have the meaning that the Rules give them.
16. I consent to the recording of all conversations between me and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I also consent to all these records remaining the sole property of the Scheme and the Administrator.
17. I acknowledge that my duly appointed financial adviser will have access to my membership information and that this access will stay in-force until I notify the Scheme of a change in financial adviser.
18. I understand that I need to provide full and complete information, even if I have already done so for other policies held with any of the subsidiaries of MMI Group Holdings Limited, as Momentum Health and MMI Holdings are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants and I are accepted as members of the Scheme, my answers on this application will form the basis of our membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser, or any other third party on my behalf.**

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

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

Signed at

Starting date* **0 1** – M M – **2 0** Y Y

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

Signature of principal member

Date D D – M M – **2 0** Y Y

momentum

Application for complementary products

2019

Important notes:

- You can choose to make use of additional products available from Momentum Group, a division of MMI Group Limited (Momentum), to seamlessly enhance your medical aid. These voluntary complementary products range from a world-class wellness and rewards programme, Multiply, to the innovative HealthReturns solution. These complementary products are not medical scheme benefits. Momentum is not a medical scheme, and is a separate entity to Momentum Health. You can be a member of Momentum Health without taking any of the complementary products that Momentum offers.
- If you choose to take any of these products, please complete the contract details for each product you require.

Section 1: Multiply contract details

Section 1.1

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

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

How would you like to receive your Multiply welcome pack?				
	Mail to member's postal address	☐	Member to collect	☐
	Send to branch	☐	Financial adviser to collect	☐

Section 1.2

You only need to complete this section if you do not have a South African ID number. Please provide a copy of your passport.

Principal member

Passport number			
Date of issue	D D – M M – Y Y Y Y	Expiry date	D D – M M – Y Y Y Y
Country of issue			
Nationality			
Tax reference number			
Tax residency country			

Spouse or partner (if applicable)

Passport number			
Date of issue	D D – M M – Y Y Y Y	Expiry date	D D – M M – Y Y Y Y
Country of issue			
Nationality			
Tax reference number			
Tax residency country			

Section 1.3: Financial adviser for Multiply membership

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

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

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

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

Section 2: HealthSaver contract details

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

Section 2.1: Free HealthSaver account

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

Section 2.2: HealthReturns

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

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

Section 2.3: Monthly HealthSaver

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

Monthly amount R | | | | | | | Minimum of R100 per month

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

Section 2.4: 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). We will use this information to carry out a credit check.

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

Credit provider information

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

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

Section 2.5: Claims payment

In-hospital claims:

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

Day-to-day claims:

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

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

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

Section 2.6: Multiply Visa® Card

You can apply for a maximum of 2 cards. Cardholders must be registered dependants on the medical aid.

Account holder: As the principal member, you will be the account holder.

Cardholder (HealthSaver investor)

☐ Tick this box if you (the account holder) want to apply for a Multiply Visa® Card

Section 2: HealthSaver contract details (continued)

Section 2.6: Multiply Visa® Card (continued)

☐ Tick this box if you want an additional Multiply Visa® Card

Additional cardholder

Title | Initials | First name

Surname

Previous surname | Gender Male ☐ Female ☐

ID number | Date of birth D D – M M – Y Y Y Y

Passport number

Date of issue D D – M M – Y Y Y Y | Expiry date D D – M M – Y Y Y Y

Country of issue

Nationality

Tax reference number

Tax residency country

Telephone - home | Telephone - work

Cellphone number

Email address

☐ Tick this box if you want an additional Multiply Visa® Card

Additional cardholder

Title | Initials | First name

Surname

Previous surname | Gender Male ☐ Female ☐

ID number | Date of birth D D – M M – Y Y Y Y

Passport number

Date of issue D D – M M – Y Y Y Y | Expiry date D D – M M – Y Y Y Y

Country of issue

Nationality

Tax reference number

Tax residency country

Telephone - home | Telephone - work

Cellphone number

Email address

Section 3: AdviceFee contract details

Please select one of the following AdviceFee options:

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

Standard monthly amount R45 ☐ R83 ☐ R111 ☐ R132 ☐ | Increase option Annual Increase ☐

Section 4: Banking details for payment of contributions

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

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

Section 4: Banking details for payment of contributions (continued)

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

Name of account holder

Name of bank

Account number

Account type Current/Cheque Savings Transmission

Branch code - - - Branch name

Section 5: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

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

If an **individual's** account is to be debited, please sign below:

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

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

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

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

Name

Position in company

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

Company stamp

Section 6: Terms and conditions

For protection of personal information

MMI comprises a group of companies that provide the following products and services:

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

MMI and its subsidiaries will keep your personal information confidential and will adhere to the Protection of Personal Information Act 4 of 2013 when processing your personal information. We request your consent to process your personal information and to obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement to enable MMI and its subsidiaries to offer you the products set out above and to administer the products.

1. I confirm that I am authorised to provide consent in this section on behalf of my dependants.
2. I authorise and give consent to MMI to process, further process and share my personal information, including health information, and that of my dependants, for purposes of any products and services with the subsidiaries of MMI.
3. I understand that the personal information will be shared to provide for the following purposes:
   - To interact with, and view all the products and services I have with the MMI group of companies on its websites;
   - To provide me and my dependants' personal and health information to any other entity within the MMI Group, where I and/or my dependants already have a relationship or where I and/or my dependants have applied for a product or benefit, for the administration, underwriting and risk profile analysis of my and/or my dependants' products or benefits.
4. I understand that I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
5. I understand that I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
6. I understand that if I fail to provide the personal information required or if I am not willing to agree to the processing of my personal information, then MMI and its subsidiaries will not be able to offer me the products or to administer them. My personal information will be processed in terms of the Medical Schemes Act 131 of 1998, the Financial Intelligence Centre Act 38 of 2001, the Financial Advisory and Intermediary Act 37 of 2002, the Long-Term Insurance Act 52 of 1998, and the Pension Funds Act 24 of 1956.

Section 6: Terms and conditions (continued)

For protection of personal information (continued)

7. I understand that I have the right to request my personal information which is under the control of MMI and its subsidiaries provided that I furnish adequate identity and that a fee may be charged for this service.
8. I understand that I have the right to request MMI and its subsidiaries where necessary, to correct, or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
9. If I have a complaint relating to the processing of my personal information, I understand that I should first refer it to MMI to resolve it in terms of their internal complaints process. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.

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

For Multiply

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

For HealthSaver

1. I am deemed to have read and understood the Rules and Conditions that apply to HealthSaver, which can be accessed via the website at momentum.co.za, and consider myself bound by these Rules and Conditions. I further agree to refer to the Momentum website (momentum.co.za) annually to take note of the terms and conditions.
2. I appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the HealthSaver and for making the relevant payments as per the Rules and Conditions.
3. I acknowledge that:
   i. In doing so, Momentum acts as my agent.
   ii. I assume all risks connected with the administration of the entrusted funds by Momentum, understanding that Momentum is bound by the Financial Institutions (Protection of Funds) Act 28 of 2001.
   iii. I will direct all enquiries in respect of the HealthSaver to Momentum.

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

For HealthSaver: Credit granting for application

1. I confirm that the above information is true and complete.
2. I understand that the information provided under the Credit Assessment Inventory will yield a net income figure and that this will determine whether credit will be granted.
3. I understand that the maximum credit I can qualify for is R36 000.
4. I agree that ad-hoc contributions and rebates will not affect the credit advanced to me.
5. I agree that my application is subject to verification, processing and screening and that Momentum may decline an application based on these checks. In addition I give consent that upon acceptance my application will still be subject to continuous screening which may lead to the termination of my application or a reduction in the amount advanced to me when necessary.
6. Momentum reserves the right to share my payment behaviour with various credit bureaus and I understand that this will have an impact on my credit worthiness.
7. Momentum will send the pre-agreement once the application has been processed. I acknowledge that when I receive the pre-agreement, I am obligated to respond to the confirmation email containing the Schedule of the HealthSaver. My response will indicate my approval for Momentum to activate the HealthSaver account. I acknowledge that if my response is not received within the required time specified in the communication, my HealthSaver will be activated without credit.
8. 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;
9. 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.
10. I understand that credit granted will be subject to a variable interest rate.

Section 6: Terms and conditions (continued)

For Multiply Visa® Card

Please read the statements below and sign your acceptance thereof.

1. If you apply for the Multiply Visa® Card and thereafter decline delivery, charges may apply.
2. By applying for the Multiply Visa® Card, I am deemed to have read and understood the Terms and Conditions for Use of the card which can be accessed via the Multiply website at multiply.co.za, and consider myself bound by these Terms and Conditions of Use. If I do not agree with the Terms and Conditions, my application for the card cannot be processed.
3. If I am a Multiply Starter member, a monthly fee of R11 is payable for the card and this fee will be debited from my HealthSaver account.
4. Multiply will verify my identity and residential address and they may decline to issue or activate a card if I cannot give them satisfactory proof of my identity and residential address as per the FICA (Financial Intelligence Centre Act) requirements.
5. There must be funds available in my HealthSaver Account for a transaction to be authorised.
6. The card can be used at medical service providers, standalone pharmacy front shops (such as Dis-Chem, Clicks and Link pharmacies) and veterinarians within the borders of South Africa.
7. The card cannot be used to withdraw cash at a bank, an ATM or a Merchant, nor can it be used to pay in-store Merchant accounts.
8. I can cancel my card at any time by notifying Multiply in writing and I must then destroy the card by cutting through the magnetic strip and card numbers. I understand that I will be legally responsible for any transactions if the card is not properly destroyed and is used by any unauthorised person.
9. Multiply will treat all my personal information as private and confidential. I agree that they may share my personal information with third party services providers for the operation of this card.

For AdviceFee

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

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

Signed at

Signature of principal member

Date D D – M M – **2 0** Y Y

GapCover

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

DomestiCare

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