

# Individual Application for membership

Includes Health Saver, Multiply, Advice Fee and Health Waiver

2011

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

## Section 1: Personal details

### Principal member

Title	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*If passport number, please supply date of birth					
Country in which passport was issued	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>	Marital status	<input type="text"/>
Residential address	<input type="text"/>				
	<input type="text"/>				
	<input type="text"/>				
Postal address (if different)	<input type="text"/>				
	<input type="text"/>				
	<input type="text"/>				
Telephone - home (code - number)	<input type="text"/>	<input type="text"/>	<input type="text"/>	Cellphone number	<input type="text"/>
E-mail address	<input type="text"/>				

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

A mobicard will be sent to you via sms

What prompted you to join Momentum Health?

Financial Adviser ☐ Advertising ☐ Internet ☐ Personal Recommendation ☐

Other, please specify details

### Spouse or partner

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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*If passport number, please supply date of birth					
Country in which passport was issued	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>	Marital status	<input type="text"/>
Telephone - home (code - number)	<input type="text"/>	<input type="text"/>	<input type="text"/>	Cellphone number	<input type="text"/>
E-mail address	<input type="text"/>				

### Dependants

First name	Surname if different to principal member	ID number/ Passport No	Country in which passport was issued	Date of birth	Gender (M/F)	Relationship to principal member
1.						
2.						
3.						
4.						
5.						

## Section 1: Personal details (continued)

To be completed for dependants over age 21 (not including spouse)

Are the adult dependants financially dependent on the principal member?

Yes

No

Name of adult dependant 1

Monthly income R

Cellphone number

E-mail address

Name of adult dependant 2

Monthly income R

Cellphone number

E-mail address

Name of adult dependant 3

Monthly income R

Cellphone number

E-mail address

Name of adult dependant 4

Monthly income R

Cellphone number

E-mail address

## Section 2: Employer information

### Non-government employees

Company Name

Branch name Branch number

Existing group number Employee number

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

Principal member's monthly income

Principal member's occupation

### Government employees

Name of department

Persal Number\* Date of employment D D - M M - Y Y Y Y

\*Please attach a copy of your latest payslip

Principal member's monthly income

Principal member's occupation

## Section 3: Business information if self-employed

Company Name

Registration number Registration date D D - M M - 2 0 Y Y

Nature of Business

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

Cellphone number Preferred method of communication: E-mail Post

E-mail address

Business physical address

Postal code

Business postal address (if different)

Postal code

## Section 4: Financial adviser

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

Signature of financial adviser

Date

D D - M M - 2 0 Y Y

How would you like to receive your welcome pack?

Mail to member

Send to branch

Broker to collect

Other (please specify)

## Section 5: Marketing adviser

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

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

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

Are you changing your medical scheme due to a change in your employment?

Yes ☐ No ☐

Have you, your spouse or any of your dependants ever had a waiting period, pre-existing condition exclusions or a late joiner penalty? If Yes, please attach previous membership certificate (if available).

Yes ☐ No ☐

## Section 7: Medical details

Complete Section 7.1 if you have been a member of a medical scheme registered in South Africa for at least 24-months and less than 90 days have passed since your resignation from that scheme. If not, please complete Section 7.2.

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

### SECTION 7.1

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

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

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

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

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

### SECTION 7.2

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

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 ever had any of the following:

- |       |  |                              |                             |
|-------|--|------------------------------|-----------------------------|
| 7.2.1 | <b>Disorders or problems with the heart or cardiovascular system.</b> Eg. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|-------|--|------------------------------|-----------------------------|

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

- |       |   |                              |                             |
|-------|---|------------------------------|-----------------------------|
| 7.2.2 | <b>Respiratory or lung trouble.</b> Eg tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|-------|---|------------------------------|-----------------------------|

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

- |       |  |                              |                             |
|-------|--|------------------------------|-----------------------------|
| 7.2.3 | <b>Disorders of the digestive system, stomach, gall bladder, pancreas of liver.</b> 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 <input type="checkbox"/> | No <input type="checkbox"/> |
|-------|--|------------------------------|-----------------------------|

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

## Section 7: Medical details (continued)

7.2.4 **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

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

Yes ☐

No ☐

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

7.2.11 Are you or any of your dependants currently undergoing, or anticipating any specialised dental/maxillo facial treatment?

Yes ☐

No ☐

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

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

Yes ☐

No ☐

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

7.2.13 Are you or any of your dependants taking ongoing medication for any condition not listed in any other question?

Yes ☐

No ☐

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

## Section 7: Medical details (continued)

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

Yes ☐

No ☐

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

7.2.15 Are you or any of your dependants awaiting or planning any 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

7.2.16 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months?

Yes ☐

No ☐

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

Questions 7.2.17 to 7.2.18 apply to female applicants

7.2.17 **Gynaecological disorders.** Eg abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormality of pregnancy or confinement?

Yes ☐

No ☐

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

7.2.18 Are you currently pregnant?

Yes ☐

No ☐

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

### 7.2.19 Principal member

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

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

### Spouse or partner

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

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

### Adult dependant 1

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

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

### Adult dependant 2

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

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

### Adult dependant 3

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

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

### Adult dependant 4

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

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

## Section 7: Medical details (continued)

7.2.20 Have you taken out a life insurance policy with Momentum during the last six months?

Yes

No

If Yes please supply your policy number.

### Current doctor

Name and surname

Telephone - work (code - number)

How long has he/she been your doctor?

### Current dentist

Name and surname

Telephone - work (code - number)

How long has he/she been your dentist?

## Section 8: Option choice

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

<b>Ingwe Option</b>	<b>Hospital provider</b>	<b>Chronic and Day-to-day provider</b>	<b>Salary</b>
	Ingwe Network	CareCross	R8 001 or more
	State	Prime Cure	R6 001 - R8 000*
			R3 751 - R6 000*
			Less than R3 750*
Provider's practice number			
Provider's practice name			

\* If less than R8 000, please attach a copy of your payslip

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

<b>Custom Option</b>	<b>Hospital provider</b>	<b>Chronic and Day-to-day provider</b>
	Any hospital	Any
	Associated hospitals	Associated GP and Courier Pharmacies
		State

<b>Incentive Option</b>	<b>Hospital provider</b>	<b>Chronic and Day-to-day provider</b>	<b>Savings:10%</b>
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	

<b>Extender Option</b>	<b>Hospital provider</b>	<b>Chronic and Day-to-day provider</b>	<b>Savings:25%</b>
	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	

<b>Summit Option</b>	<b>Hospital provider: Any hospital</b>	<b>Chronic and Day-to-day provider: Freedom-of-choice</b>
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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:

### Section 9.1

Title  Initials  First name

Surname /Name of company

ID/Passport number  Gender:

RSA ID   Date of Birth

Residential address

Postal address (if different)

Telephone - home (code - number)  Cellphone number

E-mail address

### Section 9.2

Name of account holder

Name of institution

Account number

Account type:

Branch code  Branch name

## Section 10: Details for contribution collection

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

Position in company

**Signature of account holder/  
Authorised signatory**

**Date**  –  –

**Company Stamp**

## 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

Name of institution

Account number

Account type:

Branch code  Branch name

**Signature of principal member**

**Date**  –  –

## 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.
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, authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.
12. In the case of new members of the Scheme, the following may apply:
  - A three-month general waiting period;
  - A twelve-month exclusion on a pre-existing condition; and/or
  - Late-joiner contribution penalty.
13. I will notify the Scheme if I or any of my dependants are living with HIV/Aids.
14. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.
15. I 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 <input type="checkbox"/>	No <input type="checkbox"/>
<b>Signed at</b>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Starting date</b>	<div style="border: 1px solid black; padding: 2px; display: flex; align-items: center;"><div style="border: 1px solid black; padding: 0 5px;">0</div><div style="border: 1px solid black; padding: 0 5px;">1</div><div style="margin: 0 5px;">-</div><div style="border: 1px solid black; padding: 0 5px;">M</div><div style="border: 1px solid black; padding: 0 5px;">M</div><div style="margin: 0 5px;">-</div><div style="border: 1px solid black; padding: 0 5px;">2</div><div style="border: 1px solid black; padding: 0 5px;">0</div><div style="margin: 0 5px;">Y</div><div style="border: 1px solid black; padding: 0 5px;">Y</div></div>	
<b>Signature of principal member</b>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <div style="text-align: right; margin-top: 5px;"><b>Date</b> <div style="border: 1px solid black; padding: 0 5px;">D</div><div style="border: 1px solid black; padding: 0 5px;">D</div><div style="margin: 0 5px;">-</div><div style="border: 1px solid black; padding: 0 5px;">M</div><div style="border: 1px solid black; padding: 0 5px;">M</div><div style="margin: 0 5px;">-</div><div style="border: 1px solid black; padding: 0 5px;">2</div><div style="border: 1px solid black; padding: 0 5px;">0</div><div style="margin: 0 5px;">Y</div><div style="border: 1px solid black; padding: 0 5px;">Y</div></div>	

The Health Saver is a free product available to all Momentum Health members. We need your consent to activate your Health Saver account. (See page 9)



# Annexure for complementary products

2011

## Important notes:

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

## Product Selection:

Please indicate which Complementary products you are applying for, complete relevant sections and sign page 13.

Health Saver ☐

Multiply ☐

Advice Fee ☐

Health Waiver ☐

## Section 1: Health Saver contract details

Sign below if you would like Momentum to activate your free Health Saver account. You can use this account as you see fit to make provision for additional healthcare expenses

<b>Signature</b>		<b>Date</b>
		<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</div> </div>

Complete the section below if you wish to make monthly contributions to the Health Saver.

Monthly Health Saver amount **R**

and/or upfront single amount **R**

Do you require credit ☐ Yes ☐ No ☐

\*Credit not available on single upfront amounts

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

## Credit assessment inventory (complete if credit option was selected)

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 2: 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 3: Advice Fee Contract details

Please select one of the following Advice Fee options:

Standard monthly amount

R 55.00

R 70.00

R 85.00

Increase option

Annual review

None

Note: If group pays for Advice Fee, amount will be as per the group amount selected.

Section 4: Health Waiver

Section 4.1 Insured life/lives

Insured life/lives:

Principal member

Spouse

Section 4.2 Contract details

Benefit payment term:

5 years

10 years

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

Principal member:

Yes

No

Spouse:

Yes

No

Medical disclaimer

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

Principal member:

Yes

No

If yes,

Condition/impairment

Doctor's name

Currently on treatment?

Last symptoms

Fully recovered?

Yes

No

Y

Y

M

M

Yes

No

Spouse:

Yes

No

If yes,

Condition/impairment

Doctor's name

Currently on treatment?

Last symptoms

Fully recovered?

Yes

No

Y

Y

M

M

Yes

No

Exclusion for pre-existing condition

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

Signature of principal member

Signature of spouse

Date

Date

Section 4.3 Start of policy

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

Automatic starting date\*

x

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

Section 4.4 Replacement of insurance

Do any benefits under this policy replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance that you discontinued within the past four months or that you will discontinue within the next four months)?

Yes

No

## Section 4: Health Waiver (continued)

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

### Section 4.5 Policy Holder details

Name of legal entity	<input type="text"/>																																			
Contact person in case of legal entity	<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"/>	2	<input type="text"/>	0	<input type="text"/>	<input type="text"/>									
Postal address	<input type="text"/>																																			
	<input type="text"/>																																			
	<input type="text"/>																																			
Telephone - work (code - number)	<input type="text"/>													Fax - work (code - number)	<input type="text"/>																					
Cellphone number	<input type="text"/>													Correspondence language:	<input type="text"/>																					
E-mail address	<input type="text"/>													Preferred method of communication:	<input type="text"/>																					
Tax status:	Company / Close Corporation (M) <input type="checkbox"/>													Natural persons (N) <input type="checkbox"/>													Nontaxable Institution(I) <input type="checkbox"/>									
Tax status of trust beneficiaries if the applicant is a trust company	Company (C) <input type="checkbox"/>													Natural persons (P) <input type="checkbox"/>													Nontaxable Institution(Z) <input type="checkbox"/>									

## Section 5: Contribution payer information

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

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

Is the contribution payer the:	Principal Member (complete only section 5.2) <input type="checkbox"/>																									
	Company (as per company application form – ignore sections 5.1 and 5.2) <input type="checkbox"/>																									
	Other (complete sections 5.1 and 5.2) <input type="checkbox"/>																									

### Section 5.1

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>																																												
Surname /Name of company	<input type="text"/>																																																
ID/Passport 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"/>	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender:	Male <input type="checkbox"/>		Female <input type="checkbox"/>																	
RSA ID	Yes <input type="checkbox"/>		No <input type="checkbox"/>		Date of Birth																					<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"/>	<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"/>
Residential address	<input type="text"/>																																																
	<input type="text"/>																																																
	<input type="text"/>																																																
Postal address (if different)	<input type="text"/>																																																
	<input type="text"/>																																																
	<input type="text"/>																																																
Telephone - home (code - number)	<input type="text"/>													Cellphone number	<input type="text"/>																																		
E-mail address	<input type="text"/>																																																

### Section 5.2

(Please do not provide credit card details. Momentum 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:	Current <input type="checkbox"/>		Savings <input type="checkbox"/>		Transmission <input type="checkbox"/>		Deduction date		<input type="text"/>	<input type="text"/>	0	<input type="text"/>	1	<input type="text"/>													
Branch code	<input type="text"/>													Branch name	<input type="text"/>												
Should Momentum group* all collections from this account number and deduct them from your account as one amount?	Yes <input type="checkbox"/> No <input type="checkbox"/>																										

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

## Section 6: Details for contribution collection

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

If a company account is to be debited:

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

Name	<input type="text"/>
Position in company	<input type="text"/>
Signature of account holder/ Authorised signatory	<div><input type="text"/></div> <div><input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></div>

## Section 7: Terms and conditions

### For Health Saver

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

### Credit granting for applications

1. I confirm that the above information is true and complete.
2. I understand that the information provided under the Credit Assessment Inventory will yield a Net income figure and that this will determine whether credit will be granted.
3. I understand that the maximum credit I can qualify for is R18 000.
4. I agree that ad-hoc contributions and rebates will not affect the credit advanced to me.
5. I agree that my application is subject to verification, processing and screening and that Momentum may decline an application based on these checks. In addition I give consent that upon acceptance my application will still be subject to continuous screening which may lead to the termination of my application when necessary.
6. I understand that credit granted will be 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](http://www.momentum.co.za)) or the Multiply client contact centre at 0861 88 66 00.
2. I consent to paying the monthly contributions in return for the benefits supplied by Multiply to my dependants (where applicable) and myself. I understand that it is my sole responsibility to ensure that my monthly contributions are received by Momentum Interactive (Pty) Ltd.
3. I acknowledge that Momentum Interactive (Pty) Ltd reserves and shall have the right to cancel the membership applied for herein if I or any of my dependants (that are members of the programme by virtue of this application) breach any of the terms and conditions of this agreement inclusive of rules and regulations pertaining to the Multiply programme in force from time to time.
4. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally from time to time, but shall inform members of any such amendments. I understand that I may cancel my participation on Multiply at any time, including when I do not accept the amended rules and benefits.

### For Advice Fee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Health Medical Scheme (Momentum Health), for a monthly fee per principal member as provided for in regulation 28(6)(b) of the Medical Schemes Act. These amounts include VAT, if applicable.
2. The services that my financial adviser has agreed to render to me include, but are not limited to:
  - handling enquiries in relation to my membership of Momentum Health
  - keeping Momentum Health informed of changes in my membership details
  - informing me of changes in my contributions to Momentum Health, and
  - advising me of changes to the product and benefits that Momentum Health offers.
3. This fee may be reviewed annually when my contributions to Momentum Health are reviewed and increased by a rate based on the average contribution increase to Momentum Health. I will receive reasonable written notice of any such intended change.
4. The agreement will start when I become a member of Momentum Health, unless stated otherwise, and will end when my financial adviser is not entitled to receive compensation for my membership of Momentum Health for any reason whatsoever.

## For Advice Fee

- ### For Health Waiver

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.

[illegible]