

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

Name of adult dependant 2

Monthly income R

Monthly income R

Cellphone number

Cellphone number

E-mail address

E-mail address

Name of adult dependant 3

Name of adult dependant 4

Monthly income R

Monthly income R

Cellphone number

Cellphone number

E-mail address

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 DD - MM - YYYY

Principal member's monthly income

Principal member's occupation

Government employees

Name of department

Persal Number* Date of employment DD - MM - YYYY
*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 DD - MM - 20YY

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 DD - MM - 20YY

How would you like to receive your welcome pack? Mail to member Send to branch Broker to collect Other (please specify) _____

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 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"/> |
| Signed at | <input type="text"/> | |
| Starting date | 0 1 - M M - 2 0 Y Y | |
| Signature of principal member | <input type="text"/> | |
| | Date | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - 2 0 Y Y |

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

| | | |
|------------------|--|---|
| Signature | | Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
|------------------|--|---|

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

Spouse: Yes No

If yes,

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

Exclusion for pre-existing condition

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

| | | | | | | | | | |
|-------------------------------|----------------------|------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Signature of principal member | <input type="text"/> | Date | <input type="text"/> |
| Signature of spouse | <input type="text"/> | Date | <input type="text"/> |

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* *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 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

Position in company

Signature of account holder/
Authorised signatory

- -

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) 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.
-

