

Individual Application for membership

Includes HealthSaver, Multiply, AdviceFee and HealthWaiver

2012

Important notes:

- Please do not resign from your current medical scheme until you have received written notification of acceptance from Momentum Health.
- Momentum Health will only consider membership on receipt of a fully completed application form.
- Please provide a copy of ID, for principal member, spouse and adult dependants.
- FICA requirements for HealthSaver: Certified proof of identification and proof of residential address (not older than 3 months)
- If this application is for groups and the company is not already listed on Momentum Health, a company application form needs to be completed.
- If this application is for Government employees, attach a copy of your latest payslip.

Section 1: Personal details

Principal member

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

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

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

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

Dependants (If dependants are also applying for membership)

Dependant 1

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

Dependant 2

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

Dependant 3

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

Dependant 4

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

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

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

Section 2: Employer information

Government employees


Name of department	
Persal Number* <small>*Please attach a copy of your latest payslip</small>	
Principal member's monthly income	
Principal member's occupation	
Date of employment	D D - M M - Y Y Y Y

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: Email 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	Commission split %
Peter Pyburn	560624	024205		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 <input checked="" type="checkbox"/>	Send to branch <input type="checkbox"/>	Other (please specify) _____

Section 5: Marketing adviser (where applicable)

Name	Shane Sun	Marketing adviser's code	
Branch name	MDS	Telephone - work (code - number)	
E-mail address	shane.sun@momentum.co.za		

Section 6: Previous medical scheme information

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

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

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

Section 6: Previous medical scheme information (continued)

Have you, your spouse or any of your dependants had a waiting period, pre-existing conditions exclusions or a late joiner penalty?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please provide details

Name	Details

Section 7: Medical details

Principal member

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

Spouse or partner

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

Adult dependant 1

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

Adult dependant 2

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

Adult dependant 3

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

Adult dependant 4

Height	<input type="text"/> , <input type="text"/> <input type="text"/> m	Tobacco smoked:	Quantity per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mass	<input type="text"/> <input type="text"/> kg	Alcohol consumed:	Quantity per week	<input type="text"/>	<input type="text"/>	Type	<input type="text"/>

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 non-disclosure. This information will be kept confidential.

Tick here to indicate that you have read the disclaimer.

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

SECTION 7.1

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 7.2.

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

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

7.1.1	Have you or your dependants 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, and 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. If you would like to provide additional information regarding these questions, you may complete section 7.2

Section 7: Medical details (continued)

SECTION 7.2

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

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

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

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

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

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

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

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

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

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

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

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

7.2.5 **Disorders of the nervous system or brain.** Eg epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have you or any of your dependants had or been advised to have an MRI or CT scan? Yes No

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

7.2.6 **Mental disorders.** Eg depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, or post traumatic stress disorder? Yes No

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

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

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

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

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

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

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

Section 8: Option choice

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

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

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

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

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

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

Summit Option	Hospital provider: Any hospital	Chronic and Day-to-day provider: Freedom-of-choice
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Section 9: Banking details for payment of contributions

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

Is the contribution payer the:

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

Section 9.1

Title	Initials	First name
Surname /Name of company		
ID/Passport number	Gender: Male	Female
RSA ID	Yes	No
	Date of Birth	

Section 9.1 (continued)

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

Section 9.2

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

Section 10: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. I / we agree to inform Momentum Health in writing of any changes that take place. I / we authorise Momentum Health to verify such account details with the financial institution. We accept that Momentum Health will debit the account on the 1st of each month or the closest working day after the 1st.

If a company account is to be debited:

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

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

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

Section 11: Banking details for claim refunds payable to member

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

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

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

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by Momentum Medical Scheme Administrators (MMSA) (the Administrator) and agree to familiarise myself with, and be bound by, the Rules of the Scheme (the Rules) if my application for membership is accepted. I understand that I may request to inspect the Rules and that, in the event of a dispute, the Rules will be decisive.
2. I acknowledge that if my dependants and I do not disclose all the information that is relevant to the assessment of this application, it will make any contracts to which this application relates null and void. I will also forfeit all contributions that I paid to the Scheme. In such an event the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on behalf of me or my dependants under such contracts.

Section 12: Terms and conditions (continued)

3. I will notify the Scheme if any alteration takes place in any circumstances on which the Scheme based its assessment of its risk after the date of this application and before the date of the Scheme's acceptance of the risk. I acknowledge that failure to do so will make any contracts to which this application relates null and void. In such event, the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on my or my dependants' behalf under such contracts.
4. I understand that this application form is valid for 30 days only.
5. I am aware that the Scheme may ask for proof of identification at any stage.
6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contribution.
 - Non-receipt of a single month's contribution will result in suspension of medical scheme benefits. This suspension will last until I have paid all contributions in arrears.
 - Non-receipt of two months' contributions will result in cancellation of my membership of the Scheme.
7. If the employer is responsible to pay my medical scheme contributions, I authorise and instruct my employer to:
 - deduct from my remuneration (and any other sums due to me) any amounts that I may owe to the Scheme from time to time; and
 - pay such amounts to the Scheme.
 I also authorise and instruct any person (such as my employer, a pension fund or provident fund) who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in the first sentence of this clause to the Scheme as and when it is due. Furthermore, I understand that I will be liable for any legal costs that may be incurred by any party in the recovery of any amount that I owe to the Scheme.
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme may result in suspension of membership and/or handover to a third party for debt collection.
9. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Scheme, my answers on this form will form the basis of my membership.
10. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that has existed on my admission date.
11. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, I authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.
12. In the case of new members of the Scheme, the following may apply:
 - A three-month general waiting period;
 - A twelve-month exclusion on a pre-existing condition; and/or
 - Late-joiner contribution penalty.
13. I will notify the Scheme if I or any of my dependants are living with HIV/Aids (see section 7, on page 4).
14. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.
15. I undertake to give 30 days notice should I wish to terminate my membership.
16. I understand that if I have selected the Ingwe or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.
17. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and / or administrator against any claim which may arise as a result of my failure to do so.
18. Words used in this application have the meaning that the Rules give them.
19. I consent to the recording of all conversations between me and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I also consent to all these records remaining the sole property of the Scheme and the Administrator.
20. I acknowledge that my financial adviser will have access to my membership information and that this access will stay in-force until I notify the Scheme of a change in financial adviser.

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

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

Signed at

Starting date - -

Signature of principal member

Date - -

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