

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	-	-
Principal member's monthly income			
Principal member's occupation			


Government employees

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

Section 3: Business information if self-employed

Company Name			
Registration number	Registration date	-	- 2 0
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 %
Peter Lyburn	24205	560624		100 %
Signature of financial adviser			Date	-
How would you like to receive your welcome pack?	Mail to member	<input checked="" type="checkbox"/> Send to branch	Broker to collect	

Section 5: Marketing adviser

Name	Marketing adviser's code
Branch name	Telephone - work (code - number)
E-mail address	

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

Section 6: Previous medical scheme information

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

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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).

Section 7: Medical details

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

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

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

SECTION 7.1

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	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"/>
7.1.3	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"/>
7.1.4	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"/>
7.1.5	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

Have you or your dependants ever had any of the following: If yes to any of the questions please provide full details, should require addition space please add an additional page to the application form.

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 or 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

Section 7: Medical details (continued)

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 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

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 **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

Section 8: Option choice

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

Base Option	Hospital provider	Chronic and Day-to-day provider	Salary
	Base Network	CareCross	R7 501 or more
	State	Faranani	R5 501 - R7 500*
		Prime Cure	R3 501 - R5 500*
Provider's practice number			Less than R3 500*
Provider's practice name			* If less than R7 500, please attach a copy of your payslip

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

Custom Option	Hospital provider	Chronic and Day-to-day provider	Savings: 7.5%
	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

(Momentum Health does not debit from credit card accounts)

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/Company name

RSA ID

Yes

No

Gender: Male

Female

ID/Passport number*

*If passport number, please supply date of birth

Section 11: 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.
8. 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.
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 understand that if I have selected the Base or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.
16. 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.
17. Words used in this application have the meaning that the Rules give them.
18. 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.
19. 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 starting date before acceptance?

Yes No

Should Momentum Health confirm your terms of acceptance?

Yes No

Starting date

0 1 - MM - 2 0 YY

Signed at

Signature of principal member

Date - - 2 0 YY