momentum
medical scheme

Individual application for membership

2025

Important notes:

- Momentum Medical Scheme is a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Momentum Medical Scheme is administered by a separate company, Momentum Health (Pty) Ltd (Administrator), part of Momentum Group Limited.
- Please do not resign from your current medical scheme until you have received written notification of acceptance from Momentum Medical Scheme.
- Momentum Medical Scheme will only consider membership on receipt of a fully completed application form.
- Please provide the ID/Passport number and copy of ID/Passport for the principal member and all dependants.
- Please ensure that the first name and surname of the principal member, spouse and dependants are completed in accordance with the ID or passport.
- It is compulsory to provide contact details for all dependants who are 18 or older. The Scheme will use the email addresses you provide when communicating with you and your dependants.
- Please provide certificates of membership for previous medical schemes, where applicable.
- It is very important to disclose full information in the medical details sections regarding any pre-existing condition or symptoms experienced by you or your dependants. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.
- Please email the completed and signed form to us at **healthnewbusiness@momentumhealth.co.za**.
- Should we not receive all the required supporting documents, it will delay the finalisation of your application.
- Momentum Medical Scheme's 2025 benefit and contribution amendments have been submitted to the Council for Medical Schemes and are subject to approval by the Regulator.

1: Personal details

Principal member

Title | Initials | First name

Surname

Previous surname | Gender: Male | Female

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

Country in which passport was issued

Country of residence

Race: African | Coloured | Indian/Asian | White | Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

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

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

Home address

Postal code

Postal address (if different)

Postal code

Cellphone number

Email address

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

Title | Initials | First name

Surname

Previous surname | Gender: Male | Female

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

Country in which passport was issued

Country of residence

Race: African | Coloured | Indian/Asian | White | Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

Cellphone number

1: Personal details (continued)

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

Email address

Are the spouse or partner's home and postal address the same as the principal member's? Yes No

If no, please complete the spouse or partner's details:

Home address

Postal code

Postal address (if different)

Postal code

Dependants (If dependants are also applying for membership)

Dependant 1

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

Relationship to principal member

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

It is compulsory to provide contact details if the dependant is 18 or older.

Cellphone number

Email address

Are the dependant's home and postal address the same as the principal member's? Yes No

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Dependant 2

First name

Surname

ID/Passport number Gender Male Female

Country in which passport was issued Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

Relationship to principal member

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

It is compulsory to provide contact details if the dependant is 18 or older.

Cellphone number

Email address

Are the dependant's home and postal address the same as the principal member's? Yes No

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

1: Personal details (continued)

Dependants (If dependants are also applying for membership) (continued)

Dependant 3

First name

Surname

ID/Passport number | Gender: Male | Female

Country in which passport was issued | Date of birth: D D M M Y Y Y Y

Race: African | Coloured | Indian/Asian | White | Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

Relationship to principal member

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

It is compulsory to provide contact details if the dependant is 18 or older.

Cellphone number

Email address

Are the dependant's home and postal address the same as the principal member's? Yes | No

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Dependant 4

First name

Surname

ID/Passport number | Gender: Male | Female

Country in which passport was issued | Date of birth: D D M M Y Y Y Y

Race: African | Coloured | Indian/Asian | White | Other

I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

Relationship to principal member

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

It is compulsory to provide contact details if the dependant is 18 or older.

Cellphone number

Email address

Are the dependant's home and postal address the same as the principal member's? Yes | No

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

2: Employer information

2.1 Non-government employees

Company name

Branch name

Existing group number | Employee number

Business telephone number | Date of employment: D D M M Y Y Y Y

2: Employer information (continued)

2.2 Government employees

Name of department

Persal number*

Date of employment D D M M Y Y Y Y

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

3: Business information if self-employed

Company name

Registration number

Registration date D D M M Y Y Y Y

Nature of business

Telephone - work

Fax number

Cellphone number

Preferred method of communication E-mail Post

Email address

Business physical address

Postal code

Business postal address (if different)

Postal code

4: Financial adviser (where applicable)

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

Signature of financial adviser

Date D D M M Y Y Y Y

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

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

5: Previous medical scheme information

List each medical scheme that you have been a member of (note that only medical schemes registered in South Africa apply). Please supply this information for yourself and all your dependants applying for membership. If more space is required, please include additional pages.

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

If no, please indicate the details separately per dependant in the table below.

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

Please provide certificates of membership for previous schemes.

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

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

6: Medical details

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

Doctor/s consulted in the past 12 months

If you or your dependants applying for membership have consulted a doctor in the past 12 months, please list all doctors that were consulted.

Name and surname

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

Name and surname

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

Name and surname

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

Living with HIV/Aids

If you or your dependants are living with HIV/Aids and you would prefer not to disclose this for confidentiality purposes, please contact LifeSense on 0860 50 60 80 within 14 days of receiving your Momentum Medical Scheme membership number, to disclose your or your dependants' condition. We may apply a 12-month condition specific waiting period for this condition or a 3-month general waiting period. If we do, we will inform you. If you do not contact LifeSense within 14 working days, we may terminate your Momentum Medical Scheme membership, as this may be considered non-disclosure of information. This information will be kept confidential.

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

6.1

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

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

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

6.1.1	Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months?	Yes ☐	No ☐
6.1.2	Have you or your dependants had an operation or admission to any hospital in the last 12 months?	Yes ☐	No ☐
6.1.3	Are you or your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months?	Yes ☐	No ☐
6.1.4	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, or that could potentially result in a medical claim within the next 12 months?	Yes ☐	No ☐

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

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

6.2

Complete Section 6.2 if:

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

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

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

6: Medical details (continued)

6.2 (continued)

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

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

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

6.2.2 **Respiratory or lung trouble.** E.g. COVID-19, tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, upper respiratory tract infection, sinusitis or allergic rhinitis? Yes ☐ No ☐

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

6.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver.** E.g. constipation, reflux, abdominal pains, 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/ dependant	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

6.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs.** E.g. urinary tract infections, abnormal urine tests, kidney stones, nephritis, prostatitis, abnormal prostate-specific antigen (PSA), bladder infections, or sexually transmitted disease? Yes ☐ No ☐

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

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

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

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

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

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

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

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

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

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

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

6: Medical details (continued)

6.2 (continued)

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

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

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

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

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

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

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

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

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

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

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

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

Questions 6.2.16 to 6.2.17 apply to female applicants

6.2.16 Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, excessive/abnormal bleeding, pelvic pains, endometriosis, ovarian cysts, Polycystic ovarian syndrome (PCOS), fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant? Yes ☐ No ☐

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

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

7: Option choice

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

Ingwe Option	**Hospital provider**	**Chronic and Day-to-day provider**
	Connect hospitals	State facilities
	Ingwe Network hospitals	Ingwe Primary Care Network provider
	Any hospital	Ingwe Active Network provider

Income

R22 401+	R17 001 - R22 400	R11 951 - R17 000	R9 001 - R11 950
R1 501 - R9 000	≤ R1500		

*If less than R22 401, please complete the **Declaration of Income**

GP's practice number

GP's name

If you choose Ingwe Network hospitals, you need to nominate a doctor listed on the Ingwe Primary Care Network. If you choose Any hospital, you need to nominate a doctor listed on the Ingwe Active Network. To view the lists of providers, visit momentummedicalscheme.co.za, or WhatsApp or call us on 0860 11 78 59.

Evolve Option **Hospital provider** Evolve Network **Chronic provider** State

Custom Option

Hospital provider	**Chronic provider**	
Any hospital	Any	State
Associated hospitals	Associated GP and Courier Pharmacies	

Incentive Option **Savings: 10%**

Hospital provider	**Chronic provider**	
Any hospital	Any	State
Associated hospitals	Associated GP and Courier Pharmacies	

Extender Option **Savings: 25%**

Hospital provider	**Chronic provider**	
Any hospital	Any	State
Associated hospitals	Associated GP and Courier Pharmacies	

How would you like us to pay your day-to-day claims?

At the claims accumulation rate	At up to 200% of the Momentum Medical Scheme Rate

Summit Option **Hospital provider** Any **Chronic and Day-to-day provider** Freedom-of-choice

8: Banking details for payment of contributions

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

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

Name of account holder

Name of bank

Account number

Account type: Current/Cheque | Savings | Transmission

Branch code

Branch name

Start date: 0 1 M M Y Y Y Y

Notes:

- The deduction date is the first working day of the month.
- The abbreviated name as registered with the bank, which will reflect on your bank statement, is MOMMEDSCH followed by your group number. Your group number will be issued upon activation of your membership.

9: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Medical Scheme may debit the above account with the amount due under the contract in accordance with the Momentum Medical Scheme debit order system. Momentum Medical Scheme will debit the bank account for contributions on the 1st working day of every month. I understand that Momentum Medical Scheme bills for contributions in advance and dependent on my commencement and activation dates there may be more than a single contribution payable to the Scheme. I may cancel this mandate and pay via other methods within 30 days. If I cancel this mandate, I remain responsible to pay any amounts due to Momentum Medical Scheme while it was in force.

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

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

*Consent from third party:

I (name and surname)

ID number

consent to Momentum Medical Scheme deducting the contributions due for this member from my bank account.

Signature of principal member or third party (if applicable)

Date D D M M Y Y Y Y

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

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

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

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D M M Y Y Y Y

Company stamp

10: Banking details for claim refunds payable to member

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

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

If not, please complete the bank details below.

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

Name of account holder

Name of bank

Account number

Account type ☐ Current/Cheque ☐ Savings ☐ Transmission

Branch code Branch name

Signature of principal member

Date D D M M Y Y Y Y

11: Consent for Momentum Medical Scheme to process personal information

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

Momentum Medical Scheme and the Administrator, Momentum Health (Pty) Ltd, part of Momentum Group Limited, will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

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

11: Consent for Momentum Medical Scheme to process personal information (continued)

Please read the statements below and sign your acceptance thereof.

1. I confirm that I am authorised to provide consent on behalf of my dependants and that I have their permission to share such information with Momentum Medical Scheme and the Administrator. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and I have the authority to give consent for them.
2. I declare that all my personal information and that of my dependants supplied to Momentum Medical Scheme and the Administrator is accurate, up to date, not misleading and that it is complete in all respects and will be held and/or stored securely for the purpose for which it was collected and that I will immediately advise Momentum Medical Scheme and the Administrator of any changes to my personal information and that of my dependants should any of these details change.
3. I authorise, and give consent to Momentum Medical Scheme and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Momentum Medical Scheme membership risk profiling and management, administration of my membership and as set out in this section.
4. If I have consented to the disclosure of my personal information to any other entity or person (person means any natural or juristic person, firm, company, corporation, state, agency or organisation of a state, association, trust or partnership, whether or not having legal personality) or if a contractual relationship exists between Momentum Medical Scheme or the Administrator which requires Momentum Medical Scheme or the Administrator to provide my personal information to any other person, Momentum Medical Scheme or the Administrator may do so.
5. I acknowledge that I must give Momentum Medical Scheme and the Administrator all information and evidence they may require from time to time. I authorise Momentum Medical Scheme and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Momentum Medical Scheme may require concerning me or any of my dependants in assessing any risk or claim in relation to this application, my membership of Momentum Medical Scheme and risk profiling or management. I consent to that person providing, and instruct that person to provide, Momentum Medical Scheme and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
6. I have the right to withdraw my consent to have my personal and health information processed from the date of withdrawal of consent confirmation. I acknowledge that withdrawal of consent for processing my personal and health information may have an impact on my future membership.
7. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
8. I have the right to request my personal information which is in the possession of Momentum Medical Scheme and the Administrator, provided that I furnish adequate identification.
9. I have the right to request Momentum Medical Scheme and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
10. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Scheme to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on **010 023 5207** or via email at **POPIAComplaints@inforegulator.org.za**.
11. I hereby authorise, and give consent to Momentum Medical Scheme and the Administrator to share my personal information, including health information, and that of my dependants, with Momentum Group Limited and its subsidiaries, with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity, including contracted third parties both locally and outside the Republic of South Africa who require this information. This personal information will be processed and/or used for further processing in order to:
    - administer the products or services;
    - grant me and/or my dependants, where applicable, access to interact with Momentum Medical Scheme on its website, to obtain a single view of my products with Momentum Group Limited and for purposes of receiving any reports or statements including consolidated reporting; and
    - to provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
12. I hereby authorise and give consent to Momentum Medical Scheme and its Administrator to share my personal information* including health information** and that of my dependants, with Momentum and Momentum GapCover, where applicable. This personal information will be processed and/or used for further processing in order to administer the applicable products with Momentum. Tick here if you consent to the sharing of information with Momentum for purposes of administering the products. ☐

    * Personal information includes full names and surname, identity or passport number, contact details, medical scheme details, medical scheme membership number, membership status and corresponding dates of membership, employer group details where applicable, gender, marital status, as well as claims information.

    ** Health information includes Healthy Heart Score, including BMI, blood pressure reading, cholesterol and glucose levels (of you and your dependants), as well as claims information.
13. I (insert name and surname) _____

    hereby give my consent to Momentum Medical Scheme's Administrator, for me to receive direct marketing of complementary products and services from Momentum, to be marketed to me by means of unsolicited electronic communication. Tick here if you do not wish to receive any direct marketing. ☐
14. You can access the full privacy policy at **https://momentummedicalscheme.co.za/privacy-policy/**.

Signature of principal member _____ **Date** D D M M Y Y Y Y

12: Terms and conditions

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

    I also authorise and instruct any person (such as my employer, a pension fund or provident fund) who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in the first sentence of this clause to the Scheme as and when it is due. Furthermore, I understand that I will be liable for any legal costs that may be incurred by any party in the recovery of any amount that I owe to the Scheme.
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection. Refer to point 6.
9. I realise that I must submit evidence of my own health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that existed for a period of up to twelve (12) months prior to my application to join the Scheme.
10. I acknowledge that the Scheme has the right to apply a three-month general waiting period, a twelve-month exclusion on a pre-existing condition, and/or Late-joiner contribution penalty, where applicable.
11. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 6, on pg 4).
12. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a co-payment being applied as contained in the Scheme Rules.
13. I undertake to give a calendar month's notice should I wish to terminate my membership and/or terminate the membership of my dependants.
14. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and/or Administrator against any claim which may arise as a result of my failure to do so.
15. Words used in this application have the meaning that the Rules give them.
16. I consent to the recording of all conversations between me and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I also consent to all these records remaining the sole property of the Scheme and the Administrator.
17. I acknowledge that my duly appointed financial adviser will have access to my membership information and that this access will stay in-force until I notify the Scheme of a change in financial adviser.
18. I understand that I need to provide full and complete information, even if I have already done so for other policies held with any of the subsidiaries of Momentum Group Limited, as Momentum Medical Scheme and Momentum Group Limited are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants and I are accepted as members of the Scheme, my answers on this application will form the basis of our membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser, or any other third party on my behalf.**

12: Terms and conditions (continued)

Should Momentum Medical Scheme 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 Medical Scheme activates your membership.

Signed at

Start date* **0 1** M M Y Y Y Y

You may not backdate the start date. Your membership may only start on the first day of next month, or on the first day of the month thereafter.

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

Signature of principal member **Date** D D M M Y Y Y Y

momentum

Application for complementary products 2025

Important notes:

- Momentum Medical Scheme members may choose to make use of additional products available from Momentum Group Limited and its subsidiaries as well as Momentum Multiply (herein collectively referred to as Momentum). Momentum is not a medical scheme and is a separate entity to Momentum Medical Scheme. Momentum products are not medical scheme benefits. You may be a member of Momentum Medical Scheme without taking any of the products offered by Momentum.
- If you choose to take any of these products, please complete the contract details for each product you require.

1: Multiply contract details

1.1 Contract details

The membership composition for Multiply needs to be the same as for Momentum Medical Scheme.

☐ Tick this box if you are applying for the Evolve, Custom, Incentive, Extender or Summit Option and would like to join Multiply Inspire for free.

☐ Tick this box if you are applying for the Evolve, Custom, Incentive, Extender or Summit Option and would like to join Multiply Inspire Plus.

Your rewards will be paid as HealthReturns. You need a HealthSaver account for HealthReturns to be paid as rewards.

2025 Multiply Inspire Plus membership fees

• Main member	R207
• Partner/Spouse	R95
• Adult dependant (18 years and older)	R43
• Child dependant (7–17 years)	R27
• Child dependant (0–6 years)	Free

☐ Tick this box if you are applying for the Ingwe Option and would like to join Multiply Engage for free.

☐ Tick this box if you are applying for the Ingwe Option and would like to join Multiply Engage Plus.

Your rewards will be paid as HealthReturns into your Multiply wallet.

2025 Multiply Engage Plus membership fees

• Main member	R187
• Partner/Spouse	R85
• Adult dependant (18 years and older)	R38
• Child dependant (7–17 years)	R22
• Child dependant (0–6 years)	Free

A partner/spouse/dependant who joins Multiply Inspire Plus or Multiply Engage Plus must be registered on your medical aid. Please add the details of all members 18 years and older on your medical aid option below. If more space is required please include additional pages.

First name

Surname

Date of birth D D M M Y Y Y Y Relationship to principal member

Email address

Cellphone number

First name

Surname

Date of birth D D M M Y Y Y Y Relationship to principal member

Email address

Cellphone number

First name

Surname

Date of birth D D M M Y Y Y Y Relationship to principal member

Email address

Cellphone number

1: Multiply contract details

1.2

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

Main member

Passport number

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

Country of issue

Nationality

Tax reference number

Tax residency country

Spouse or partner (if applicable)

Passport number

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

Country of issue

Nationality

Tax reference number

Tax residency country

1.3 Financial adviser for Multiply membership

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

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

Signature of financial adviser **Date** D D M M Y Y Y Y

Signature of financial adviser **Date** D D M M Y Y Y Y

2: HealthSaver contract details

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

Your HealthReturns will be paid into your HealthSaver account.

2.1 FICA verification

In terms of the Financial Intelligence Centre Act (FICA), we need to successfully perform FICA verification before we activate the HealthSaver account.

If a third party pays your HealthSaver contribution, FICA is required for the third party as well.

We therefore require the following information:

- Source of funds for payment of contributions
  - Income (salary, commission and rentals)
  - Dividends interest and dividend income
  - Pension or provident fund, retirement annuity and annuity
  - Other (Please provide details)
- ID/Passport number for the principal member
  - If passport number, please confirm which country the passport was issued in and provide a copy of the passport.
- ID/Passport number for the contribution payer if different to principal member
  - If passport number, please confirm which country the passport was issued in and provide a copy of the passport.
- Company name and registration number if a company is the contribution payer (only required where a company application form has not been completed and submitted).
  - Company name
  - Company registration number

2: HealthSaver contract details (continued)

2.1 FICA verification (continued)

- If the contribution is paid by a trust by virtue of a testamentary disposition, by virtue of a court order, in respect of persons under curatorship, or by the trustees of a retirement fund in respect of benefits payable to the beneficiaries of that retirement fund, we require:
  - a copy of the trust deed for local trusts, or
  - a letter of authority or other official document from a competent trust registering authority in the foreign jurisdiction for foreign trusts.

For all other trusts we require the name and ID/Passport number for each trustee:

Name of trustee	**ID/Passport number**	**If passport number, please confirm which country the passport was issued in and provide a copy of the passport.**

2.2 HealthSaver

☐ Tick this box if you would like to apply for your HealthSaver account.

2.3 Monthly HealthSaver contributions

☐ Tick this box if you want to pay monthly contributions into your HealthSaver account and complete the contribution below.

Monthly amount R Minimum of R100 per month

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

2.4 Apply for credit

☐ Tick this box if you want to apply for credit on the above monthly amount and complete the information below.

Credit assessment inventory. We will use this information to carry out a credit check.

Where required, we will request your written approval in order to make the credit value available to you.

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 Metropolitan Life Limited
Physical Address	268 West Avenue Centurion Gauteng 0157
Contact number	0860 11 78 59 Weekdays 08:00 to 17:00

2.5 Claims payment

In-hospital claims:

☐ Tick this box if you do not want any shortfalls in your in-hospital claims to be paid automatically from your available HealthSaver funds, for example if you have a gap cover product.

Day-to-day claims:

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

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

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

2: HealthSaver contract details (continued)

2.6 HealthSaver Card

If you do not have a South African ID number, you need a passport as well as a valid visa or permit to apply for a HealthSaver Card. Please attach a copy of your passport and visa or permit.

You can apply for additional cards for your dependants, aged 18 or older, who are registered on your medical aid.

If you apply for a HealthSaver Card, certain card fees will be payable. All card fees will be debited from your HealthSaver account. The fees are subject to change in January each year. You can view the latest fees on momentum.co.za.

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

Cardholder (HealthSaver account holder)

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

Details for delivery of account holder's HealthSaver Card:

Address

Postal code

Contact person

Cellphone number

Email address

☐ Tick this box if you want an additional HealthSaver Card

Additional cardholder

Title First name

Surname

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

Passport number

Country in which passport was issued

Cellphone number*

Email address

Details for delivery of additional cardholder's HealthSaver Card:

Address

Postal code

Contact person

Cellphone number

Email address

☐ Tick this box if you want an additional HealthSaver Card

Additional cardholder

Title First name

Surname

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

Passport number

Country in which passport was issued

Cellphone number*

Email address

Details for delivery of additional cardholder's HealthSaver Card:

Address

Postal code

Contact person

Cellphone number

Email address

* We cannot process your application form for HealthSaver Card without a valid cellphone number.

If you are applying for more than two HealthSaver Cards, please include additional pages.

3: AdviceFee contract details

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

Please select one of the following AdviceFee options:

Standard monthly amount	R62 ☐	R117 ☐	R155 ☐	R184 ☐	Increase option	Annual Increase ☐

4: Banking details for payment of contributions

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

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

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

Name of account holder			
Name of bank			
Account number			
Account type	Current/Cheque ☐	Savings ☐	Transmission ☐
Branch code		Branch name	
Amount	HealthSaver R	AdviceFee R	Multiply R
Start date	0 1 M M Y Y Y Y		

Please note that the complementary product(s) will only be activated upon successful activation of your Momentum Medical Scheme membership.

Notes:

- The deduction date is the first working day of the month.
- The abbreviated name as registered with the bank, which will reflect on your bank statement, is:
  - HealthSaver: Health Sav followed by your membership number
  - AdviceFee: Advice Fee followed by your membership number
  - Multiply: Momentum followed by your membership number

5: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

I authorise Momentum to debit the account as supplied on this application form with the amount of the contribution that I have agreed to pay per complementary product. I undertake to inform Momentum of any change in the account details. I authorise Momentum to verify such account details with my financial institution. I accept that Momentum may debit the account on a date other than specified. I accept that failure to pay the amount, due and payable within 30 days from the due date, will lead to termination. I may cancel this mandate and pay via other methods within the 30 days. If I cancel this mandate, I remain responsible to pay any amounts due to Momentum while it was in force.

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

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

*Consent from third party:

I (name and surname)

ID number

consent to Momentum deducting the contributions due for this member from my bank account.

Signature of principal member or third party (if applicable)

Date D D M M Y Y Y Y

5: Authorisation for contribution collection (continued)

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

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

Name	
Position in company	

Signature of account holder/ Authorised signatory

Date D D M M Y Y Y Y

Company stamp

6: Terms and conditions

For protection of personal information

Momentum Group Limited comprises a group of companies that provide the following products and services:

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

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

1. I declare that all my personal information and that of my dependants supplied to Momentum Group Limited and its subsidiaries is accurate, up to date, not misleading and that it is complete in all respects and will be held and/or stored securely for the purpose for which it was collected and that I will immediately advise Momentum Group Limited or its subsidiaries of any changes to my personal information and that of my dependants should any of these details change.
2. I confirm that I am authorised to provide consent in this section on behalf of my dependants, and that I have their permission to share such information with Momentum Group Limited and its subsidiaries. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and I have the authority to give consent for them.
3. I hereby authorise, and give consent to Momentum Group Limited and its subsidiaries to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of Momentum Group Limited and its subsidiaries), with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity. This personal information will be processed and/or used for further processing in order to administer the products or services.
4. I understand that the personal information will be shared to provide for the following purposes:
    - To interact with, and view all the products and services I have with Momentum Group Limited on its websites including obtaining a single view of my products within Momentum Group Limited.
    - For the administration, underwriting, credit scoring, client reporting and risk profile analysis of products and services where I and/or my dependants have a contractual relationship in relation to such products or services or where I and/or my dependants have applied for such products or services.
    - To provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
    - For any other lawful purpose.
5. I acknowledge that my dependants and I must give Momentum Group Limited and its subsidiaries, as applicable, all information and evidence that may be required from time to time. I authorise Momentum Group Limited and its subsidiaries to obtain from any person, including the medical schemes to which my dependants and I belong and/or its administrator, any information Momentum Group Limited and its subsidiaries may require concerning me or any of my dependants in relation to the products or services I and/or my dependants currently have or have applied for. I consent to that person providing, and instruct that person to provide, Momentum Group Limited and its subsidiaries with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
6. I understand that I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
7. I understand that I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
8. I understand that if I fail to provide the personal information required or if I am not willing to agree to the processing of my personal information, then Momentum Group Limited and its subsidiaries will not be able to offer me the products or to administer them. My personal information will be processed in terms of the following statutes, amongst others the Medical Schemes Act 131 of 1998, the Financial Intelligence Centre Act 38 of 2001, the Financial Advisory and Intermediary Act 37 of 2002, the Long-Term Insurance Act 52 of 1998, the Insurance Act 18 of 2017, the National Credit Act 34 of 2005 and the Pension Funds Act 24 of 1956.
9. I understand that I have the right to request my personal information which is under the control of Momentum Group Limited and its subsidiaries provided that I furnish adequate identity and that a fee may be charged for this service.
10. I understand that I have the right to request Momentum Group Limited and its subsidiaries where necessary, to correct, or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.

6: Terms and conditions (continued)

For protection of personal information (continued)

11. If I have a complaint relating to the processing of my personal information, I understand that I should first refer it to Momentum Group Limited to resolve it in terms of their internal complaints process. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on **010 023 5207** or via email at **POPIAComplaints@inforegulator.org.za.**
12. You can access Momentum Group Limited's full privacy policy at **https://www.momentumgroupltd.co.za/privacy-notice** and Momentum Multiply's full policy at **https://www.multiply.co.za/engaged/privacy-policy**.

Signature of principal member **Date** D D M M Y Y Y Y

For Multiply

1. I, the main member, hereby apply for my dependants and I to join Momentum Multiply (the programme), which is administered by Momentum Multiply (Pty) Ltd (Multiply) and agree that I and my dependants will be bound by the terms and conditions and rules thereof.
2. I confirm that I am authorised to give consent on behalf of my dependants and that I have their permission to share their personal information with Multiply and any other person authorised in terms of this application. Where I give consent for a minor, I confirm that I am a competent person in respect of such a minor and I have the authority to give consent for them.
3. Multiply reserves the right to amend its rules and benefits unilaterally. A copy of the terms and conditions and rules can be obtained from https://support.multiply.co.za/hc/en-za/categories/8159122322333-Terms-and-conditions or from the Multiply client contact centre on 0861 88 66 00.
4. I undertake to obtain the necessary consents from any of my dependants to whom these terms and conditions and rules may apply and hereby indemnify Multiply against any claim which may arise as a result of my failure to do so.
5. I hereby authorise and give consent to Multiply to share my personal information, including health information, and information regarding my dependants, with my medical scheme and its administrator, with whom I and/or my dependants have a contractual relationship.
6. I acknowledge that my dependants and I must give Multiply all information and supporting evidence that may be required from time to time. I authorise Multiply to obtain any information they may require concerning me or any of my dependants in relation to my Multiply membership from any person, including the medical scheme to which my dependants and I belong and/or its administrator. I consent to that person providing, and instruct that person to provide, Multiply with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
7. I consent to the recording of all conversations between me and Multiply and all information obtained through these conversations will form part of Multiply's records. I also consent to all these records remaining the sole property of Multiply.
8. I acknowledge that Multiply reserves the right to cancel the membership applied for in this application if I or any of my dependants breach any of the terms and conditions or rules of the programme which are subject to change from time to time.
9. I understand that I will receive mandatory communication from Multiply as a legal requirement of my membership and that I am able to review and update my communication preferences by visiting the terms and conditions on the Multiply website.
10. I understand that I may contact the Multiply call centre on 0861 88 66 should I wish to cancel my membership.
11. If I have a complaint related to the product or services received, I understand that I should first refer the complaint to Multiply by calling 0861 88 66 00 or emailing multiply@momentum.co.za to resolve the complaint according to the internal complaints processes. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the National Consumer Commission by calling 012 428 7000 or emailing complaints@thencc.org.za.
12. I declare that the answers that I have provided in this application are true and complete. I understand that if my dependants and I are accepted as members of the programme, my answers on this application will form the basis of the membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by any other third party on my behalf.

For HealthSaver

1. I am deemed to have read and understood the Terms and Conditions that apply to HealthSaver, which can be accessed via the website at momentum.co.za, and consider myself bound by these Terms and Conditions. I further agree to refer to the Momentum website (momentum.co.za) annually to take note of the terms and conditions.
2. An annual administration fee of R40 is payable in January of each year.
3. I appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the HealthSaver and for making the relevant payments as per the Terms and Conditions.
4. I acknowledge that:
   i. In doing so, Momentum acts as my agent.
   ii. I assume all risks connected with the administration of the entrusted funds by Momentum, understanding that Momentum is bound by the Financial Institutions (Protection of Funds) Act 28 of 2001.
   iii. I will direct all enquiries in respect of the HealthSaver to Momentum.
   iv. I undertake to submit the information required for FICA purposes within 14 (fourteen) days of my application. Failure to submit the FICA information will result in my application for the HealthSaver account being cancelled.

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

6: Terms and conditions (continued)

For HealthSaver: Credit granting for application

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

For HealthSaver Card

Please read the statements below and sign your acceptance thereof.

1. By applying for the HealthSaver Card, I am deemed to have read and understood the Terms and Conditions for Use of the card which can be accessed via the Momentum website at momentum.co.za, and consider myself bound by these Terms and Conditions of Use. If I do not agree with the Terms and Conditions, my application for the card cannot be processed.
2. Card fees are payable for the HealthSaver Card, which will be debited from my HealthSaver account. The fees are subject to change in January each year. The latest fees can be accessed via the Momentum website at momentum.co.za.
3. Momentum will verify my identity and may decline to issue or activate a card if I cannot give them satisfactory proof of my identity as per the FICA (Financial Intelligence Centre Act) requirements.
4. Although a HealthSaver account is owned by the principal member, additional cards, for dependants 18 and older registered on the medical aid, may be linked to the account, thereby enabling additional users to also have access to available funds in the account. The principal member may activate the additional cards on behalf of the dependant. HealthSaver statements are sent to the principal member.
5. There must be funds available in my HealthSaver account for a transaction to be authorised.
6. The card can be used at medical service providers, standalone pharmacy front shops (such as Dis-Chem, Clicks and Link pharmacies) and veterinarians within the borders of South Africa.
7. The card cannot be used to withdraw cash at a bank, an ATM or a Merchant, nor can it be used to pay in-store Merchant accounts.
8. I can cancel my card at any time by notifying Momentum in writing and I must then destroy the card by cutting through the magnetic strip and card numbers. I understand that I will be legally responsible for any transactions if the card is not properly destroyed and is used by any unauthorised person.
9. Momentum will treat all my personal information as private and confidential. I agree that they may share my personal information with third party services providers for the operation of this card.

For AdviceFee

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

6: Terms and conditions (continued)

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

Signed at	
Signature of principal member	**Date** D D M M Y Y Y Y

GapCover

Take care of medical practitioner shortfalls and co-payments for in-hospital procedures through Momentum GapCover. Momentum GapCover is underwritten by Guardrisk Insurance Company Limited, a wholly owned subsidiary of Momentum Group Limited. To apply, please speak to your financial adviser.