momentum
medical scheme

Application for membership – Local student

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, where applicable.
- If a third party will be paying your contribution, please provide a copy of their ID.
- 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 attach proof of full time studies at a registered academic institution.
- Please provide certificates of membership for previous medical schemes, where applicable.
- Momentum Medical Scheme reserves the right to request proof of income from the member.
- It is very important to disclose full information in the medical details sections regarding any pre-existing conditions 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 submit the completed and signed form via email to **studentapplication@momentum.co.za.**
- **Should we not receive all the required supporting documents, it will delay the finalisation of your application.**

1: Personal details

Principal member

Name of institution where studying

Campus | Student number

Title | Initials | First name

Surname

Identity number | Date of birth (D D M M Y Y Y Y)

Gender: Male | Female | Marital status

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

Email address

Home address

Postal code

Postal address (if different)

Postal code

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.

1: Personal details (continued)

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

Cellphone number

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

1: Personal details (continued)

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

Dependant 2 (continued)

Are the dependant's contact details 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 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: 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).

3: Medical details

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.

3.1

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 3.2.

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:

3.1.1 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 ☐

3.1.2 Have you or your dependants had an operation or admission to any hospital in the last 12 months? Yes ☐ No ☐

3.1.3 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 ☐

3.1.4 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

3: Medical details (continued)

3.2

Complete Section 3.2 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.

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

3.2.1 **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

3.2.2 **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

3.2.3 **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

3.2.4 **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

3.2.5 **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

3.2.6 **Mental disorders.** E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, stress, post-traumatic stress disorder or 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

3.2.7 **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

3: Medical details (continued)

3.2 (continued)

3.2.8 **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

3.2.9 **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

3.2.10 **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

3.2.11 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

3.2.12 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

3.2.13 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

3.2.14 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

3.2.15 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 3.2.16 to 3.2.17 apply to female applicants

3.2.16 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

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

4: Option choice

Ingwe Option	Hospital provider	Chronic and Day-to-day provider	
	Ingwe Network	Ingwe Primary Care Network	
	Any hospital	Ingwe Active Network	

Please confirm the combined gross monthly income for you and your spouse or partner if he/she is included on your membership.

Gross monthly income* R

*** If you and/or your spouse or partner (if he/she is included on your membership) earn an income, you need to complete the Declaration of Income for new membership applications form.**

5: Banking details for payment of contributions

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

Name of account holder

Account holder cellphone number

Account holder email address

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.

6: 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 account holder **Date** D D M M Y Y Y Y

7: 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 a 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					
Account holder cellphone number					
Account holder email address					
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

8: 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.

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**.

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

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. You may choose to make use of additional Complementary products available from Momentum Multiply and Momentum Group Limited and its subsidiaries (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.

    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

9: 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.

9: Terms and conditions (continued)

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 3, 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.**

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

10: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code

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

For office use

Group code Institution code