

Option Selection Form

2016

Important notes:

- You only need to complete this form if you want to change your current option and/or choice of provider. Please ensure that all the selections for your chosen option are completed. Incomplete information will cause a delay in the processing of your option change.
- If your employer pays your contributions, please submit this form, fully completed, to your HR or Payroll department.
- If you are an individual member, please fax this form, fully completed, to the Momentum Health membership department on **0860 77 55 66** or email it to **mhmembership@momentum.co.za**
- This form must reach Momentum Health by no later than 20 November 2015. The requested changes will be effective from 1 January 2016.

Member details

Member number	<input type="text"/>	Employee number	<input type="text"/>
Title	Initial/s	Surname	
ID number			Cellphone number
Email			

Ingwe Option	Hospital provider	Chronic and Day-to-day provider	Income
	State hospitals	Ingwe Primary Care Network provider	More than R10 401
	Ingwe Network	Ingwe Primary Care Network provider	R7 801 - R10 400*
	Any hospital	Ingwe Active Primary Care Network provider	R5 801 - R7 800*
Provider's practice number	<input type="text"/>		R601 - R5 800*
Provider's practice name	<input type="text"/>		≤ R600*
			<small>*If less than R10 401, please complete the Declaration of Income</small>

Access Option	Hospital provider	Chronic and Day-to-day provider	
	Access Network	Access Primary Care Network	
Provider's practice number	<input type="text"/>		
Provider's practice name	<input type="text"/>		

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

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

Extender Option	Hospital provider	Chronic provider	Savings: 25%
	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 Health Rate

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

I confirm that I understand the benefits offered under the option I have selected and agree to be bound by the Rules applicable thereto. I agree to pay the relevant contribution according to the option and providers I have selected.

Signature of Principal Member	Date
<input type="text"/>	<input type="text"/>

Employer approval (to be completed if your employer pays your contributions)

Name	<input type="text"/>
Designation	<input type="text"/>

Signature of authorised person	Employer stamp
<input type="text"/>	<input type="text"/>
Date	<input type="text"/>

Declaration of Income

2016

Membership number

This form is to be completed if you are a member of the Ingwe Option or wish to join the Ingwe Option.

In order to calculate the contribution payable, income will be determined as follows:

If you are the only person registered on your Momentum Health membership, and you are:

- Gainfully employed – your gross monthly salary as confirmed by your employer
- Self-employed – your gross monthly income as confirmed by audited financial statements and/or bank statements
- Unemployed – total amount you pay for monthly household expenses
- Pensioner – the higher of your social pension or the total amount you pay for monthly household expenses.

If there are one or more adult dependants registered on your Momentum Health membership, each registered dependant's income must be determined individually as outlined above and the highest amount from amongst the registered beneficiaries shall be the income.

We will need proof of your income (see Section 1).

Please submit the completed form and supporting documents to us via email at mhmembership@momentum.co.za or fax to **0860 77 55 66**.

Section 1: Proof of income

Please provide us with the following documents as proof of income (please note that the documents are required for you, your spouse/partner and each adult dependant included on your membership):

- If employed, your latest payslip or IRP5 certificate. If you earn a variable income please provide us with your last 3 months' payslips.
- If self-employed, copies of the latest current audited financial statements of your company and the last 3 months' bank statements for you and your company
- If unemployed, your last 3 months' bank statements
- If a pensioner, proof of annuity or pension income (a letter from SASSA will be accepted) and your last 3 month's bank statements.

Section 2: Employment status, income and household expenses

Please confirm the employment status, monthly income and amount paid towards household expenses for each registered beneficiary on your Momentum Health membership.

Principal member

Employment status Employed Unemployed Self-employed Pensioner
 Monthly income R Monthly household expenses R

Spouse or partner

Employment status Employed Unemployed Self-employed Pensioner
 Monthly income R Monthly household expenses R

Adult dependant 1

Employment status Employed Unemployed Self-employed Pensioner
 Monthly income R Monthly household expenses R

Adult dependant 2

Employment status Employed Unemployed Self-employed Pensioner
 Monthly income R Monthly household expenses R

Adult dependant 3

Employment status Employed Unemployed Self-employed Pensioner
 Monthly income R Monthly household expenses R

If you have more than 3 adult dependants included on your membership, please complete their details on a separate form.

Section 3: Declaration

I confirm that all the information supplied here is true and correct.

I understand that should I make a false declaration, this may lead to termination of my Momentum Health membership.

Signature of principal member Date - -