momentum
medical scheme

Option Selection Form

2022

Important notes:

- You only need to complete this form if you want to change your current option and/or choice of provider. Please make sure 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 the fully completed form to your HR or Payroll department.
- If you are an individual member, please send the fully completed form to the Momentum Medical Scheme membership department via email at **mhmembership@momentum.co.za**.
- Please make sure that this form reaches Momentum Medical Scheme by **no later than 19 November 2021.** The requested changes will be effective from 1 January 2022.

Member details

Member number: ***5 5 4 2 8 6 4***
Employee number:
Title: ***M r***
Initial/s: ***D***
Surname: ***Van Der Walt***
ID number:
Cellphone number:
Email: ***douw.vanderwalt@afripack.cflex.com***

Ingwe Option ☐

Hospital provider	Chronic and Day-to-day provider	
State hospitals	Ingwe Primary Care Network provider	☐
Ingwe Network	Ingwe Primary Care Network provider	☐
Any hospital	Ingwe Active Primary Care Network provider	☐

Income

R14 601+	☐
R10 251 - R14 600	☐
R7 751 - R10 250	☐
R776 - R7 750	☐
≤ R775	☐

*If less than R14 601, please complete the **Declaration of Income**

GP's practice number:
GP's name:

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

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** D D M M Y Y Y Y

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

Name

Designation

Signature of authorised person **Date** D D M M Y Y Y Y

Employer stamp

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