momentum
medical scheme

Super group application for membership

2022

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 Solutions (Pty) Ltd (Administrator), part of Momentum Metropolitan Holdings 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 number and copy of ID 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.
- If your employer is not already registered as a group on Momentum Medical Scheme, a company application form needs to be completed.
- 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.

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

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

Telephone - home | 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

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

Telephone - home | Cellphone number

Email address

1: Personal details (continued)

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

Applicable if the dependant is over the age of 18:

Are the dependant's home and postal addresses 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

Cellphone number

Email address

Relationship to principal member

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

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

Applicable if the dependant is over the age of 18:

Are the dependant's home and postal addresses 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

Cellphone number

Email address

Relationship to principal member

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

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

Applicable if the dependant is over the age of 18:

Are the dependant's home and postal addresses 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

Cellphone number

Email address

Relationship to principal member

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

1: Personal details (continued)

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

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

Applicable if the dependant is over the age of 18:

Are the dependant's home and postal addresses 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

Cellphone number

Email address

Relationship to principal member

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

2: Employer information

Company Name

Branch name

Existing group number | Employee number

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

Principal member's monthly income

Principal member's occupation

3: 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.

4: 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	
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

You need to nominate a doctor listed on the Momentum Medical Scheme Ingwe or Ingwe Active Primary Care Network (depending on the network you have chosen) for your day-to-day and chronic healthcare needs. To view the lists of providers, please visit momentummedicalscheme.co.za or call us on 0860 11 78 59.

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

4: Option choice (continued)

Custom Option ☐	**Hospital provider**	**Chronic provider**	
	Any hospital ☐	Any ☐	
	Associated hospitals ☐	Associated GP and Courier Pharmacies ☐	
		State ☐	
Incentive Option ☐	**Hospital provider**	**Chronic provider**	**Savings: 10%**
	Any hospital ☐	Any ☐	
	Associated hospitals ☐	Associated GP and Courier Pharmacies ☐	
		State ☐	
Extender Option ☐	**Hospital provider**	**Chronic provider**	**Savings: 25%**
	Any hospital ☐	Any ☐	
	Associated hospitals ☐	Associated GP and Courier Pharmacies ☐	
		State ☐	
Pay day-to-day claims at:	Accumulation rate ☐	Up to 200% of the Momentum Medical Scheme rate ☐	
Summit Option ☐	**Hospital provider** Any	**Chronic and Day-to-day provider** Freedom-of-choice	

5: Employer warranty for payment of contributions

- 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.

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D M M Y Y Y Y

Company stamp

6: 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.

(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

7: 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 Solutions (Pty) Ltd, part of Momentum Metropolitan Holdings 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 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 inforeg@justice.gov.za or POPIAComplaints.IR@justice.gov.za.
9. My personal information will be shared between Momentum Medical Scheme, the Administrator, any subsidiaries within Momentum Metropolitan Holdings Limited with whom I have any financial or insurance products, including complementary products and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to my membership of Momentum Medical Scheme, and
    - to grant me access to interact with Momentum Medical Scheme on its website, to obtain a single view of my products with Momentum Metropolitan Holdings 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).
10. I agree that Momentum Medical Scheme's Administrator, Momentum Health Solutions (Pty) Ltd, may use my information for the purpose of marketing (including direct marketing) of insurance, investments, health insurance, retirement benefits, other financial services and health related products offered by Momentum Metropolitan Holdings Limited and its subsidiaries. Tick here if you do not wish to receive any direct marketing. ☐

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

8: Terms and conditions

1. I apply for my dependants and I to join Momentum Medical Scheme (the Scheme) administered by Momentum Health Solutions (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.

8: Terms and conditions (continued)

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 good health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that 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.
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 Metropolitan Holdings Limited, as Momentum Medical Scheme and Momentum Metropolitan Holdings 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

* 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 Medical Scheme 201 uMhlanga Ridge Boulevard Cornubia 4339 PO Box 2338 Durban 4000 South Africa
Client Service and Authorisation 0860 11 78 59 member@momentumhealth.co.za momentummedicalscheme.co.za
Registered in terms of the Medical Scheme Act No 131 of 1998

momentum

Application for complementary products

2022

Important notes:

- You may choose to make use of additional products available from Momentum Metropolitan Holdings Limited (Momentum), to seamlessly enhance your medical aid. Momentum is not a medical scheme, and is a separate entity to Momentum Medical Scheme. The complementary products are not medical scheme benefits. You may be a member of Momentum Medical Scheme without taking any of the complementary products.
- 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

☐ Tick this box if you would like to join Multiply Premier.

2022 Multiply Premier membership fees:

- Single member R278
- Family of two R352
- Family of three or more R386

You can choose which dependants you would like to include on your Multiply Premier membership (dependants must be registered on your medical aid). Please note that if you do not complete this section, we will default your membership fee based on the family members you have registered on your medical aid.

First name	Surname	Date of birth	Relationship to principal member
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	

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: Multiply contract details

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:

- 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
- 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.

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) ☐

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: HealthSaver contract details (continued)

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.

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

2.6 Multiply Money Card

You can apply for a Multiply Money Card if you have a valid South African ID number.

You can apply for a maximum of 2 cards for yourself and your dependants who are registered on your medical aid. If you choose not to apply for the Multiply Money Card for yourself, you may apply for 2 additional cards for your dependants who are registered on your medical aid.

If you apply for a Multiply Money card, the following fees are applicable:

• Annual primary card access fee	R180.00
• Monthly secondary card fee	R12.50
• Card issue fee	R100.00
• Card replacement (including delivery)	R170.00
• Urgent card delivery	R199.00
• Declined transactions	R4.00
• Change PIN	R2.00

All card fees will be debited from your HealthSaver account. These fees are subject to change in January each year.

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 Multiply Money Card

☐ Tick this box if you want an additional Multiply Money Card

2: HealthSaver contract details (continued)

2.6 Multiply Money Card (continued)

Additional cardholder

Title		Initials	First name
Surname			
Previous surname		Gender	Male ☐ Female ☐
ID number		Date of birth	D D M M Y Y Y Y
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			
Telephone - home		Telephone - work	
Cellphone number*			
Email address			

☐ Tick this box if you want an additional Multiply Money Card

Additional cardholder

Title		Initials	First name
Surname			
Previous surname		Gender	Male ☐ Female ☐
ID number		Date of birth	D D M M Y Y Y Y
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			
Telephone - home		Telephone - work	
Cellphone number*			
Email address			

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

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	R51 ☐	R95 ☐	R126 ☐	R150 ☐	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)	☐	☐	☐

4: Banking details for payment of contributions (continued)

(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

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 Metropolitan Holdings 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 and retirement benefits.

Momentum Metropolitan Holdings 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 Metropolitan Holdings Limited and its subsidiaries to offer you the products set out above and to administer the products.

1. I confirm that I am authorised to provide consent in this section on behalf of my dependants.
2. I authorise and give consent to Momentum Metropolitan Holdings Limited to process, further process and share my personal information, including health information, and that of my dependants, for purposes of any products and services with the subsidiaries of Momentum Metropolitan Holdings Limited.
3. 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 Metropolitan Holdings Limited on its websites including obtaining a single view of my products within Momentum Metropolitan Holdings Limited.
    - To provide me and my dependants' personal and health information to any other entity within Momentum Metropolitan Holdings Limited, where I and/or my dependants already have a relationship or where I and/or my dependants have applied for a product or benefit, for the administration, underwriting including financial underwriting, credit scoring, client reporting and risk profile analysis of my and/or my dependants' products or benefits.
    - 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).
4. 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.
5. 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.
6. 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 Metropolitan Holdings 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.
7. I understand that I have the right to request my personal information which is under the control of Momentum Metropolitan Holdings Limited and its subsidiaries provided that I furnish adequate identity and that a fee may be charged for this service.
8. I understand that I have the right to request Momentum Metropolitan Holdings Limited and its subsidiaries where necessary, to correct, or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
9. If I have a complaint relating to the processing of my personal information, I understand that I should first refer it to Momentum Metropolitan Holdings 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 inforeg@justice.gov.za or POPIAComplaints.IR@justice.gov.za.

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

For Multiply

1. I, the main member, hereby apply for membership of Multiply which is administered by Momentum Multiply (Pty) Ltd. If Multiply accepts this application, this application will serve as evidence that I agree to be bound by the rules of Multiply. I undertake to ensure adherence to the rules of the programme by myself and the members on the programme at all times. I acknowledge that Multiply Money benefits will be offered to me as a result of my Multiply membership and I consent to Momentum Multiply collecting and processing my personal information within Momentum Metropolitan Life Group and its subsidiaries and for sharing my personal information with its third party service providers for the operation of Multiply Money benefits. I also consent and give permission to Momentum Multiply to process my personal information for fraud prevention, monitoring, analytical reviews and statistical purposes where lawful and reasonable.
2. In terms of personal information provided by me on my partner or dependants (18 years or older), I confirm that I am authorised to provide their personal information to Momentum Multiply for the purpose of Multiply and Multiply Money benefits and I agree that Momentum Multiply may request consent from them for the purpose of processing their personal information, communicating and engaging with the partner or dependants (18 years or older) within Momentum Metropolitan Life Group when they participate and engage with the Multiply programme and Multiply Money.
3. I acknowledge that Multiply reserves the right to cancel the membership applied for in this form if any of the members or I breach any of the terms and conditions of this agreement, inclusive of the Multiply programme rules and applicable regulations which are subject to change from time to time.
4. Multiply reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally. Any members on the elected plan may obtain a copy of the rules from the Multiply website (multiply.co.za) or the Multiply client contact centre on 0861 88 66 00.
5. I consent that Momentum Multiply may process and retain personal information submitted by me, my financial adviser or the Multiply service provider of all members on this programme and that this information may be shared within the Momentum Metropolitan Holdings Group and Multiply service providers for the purpose of carrying out the actions for Multiply to allocate Multiply benefits which shall include various discounts, cashbacks and points, as well as communication about the Multiply programme. Yes ☐ No ☐
6. I declare that I am aware of my right of access to and the right to rectify the personal information and the existence of a right to object to the processing of personal information. I declare that the personal information provided by me is done voluntarily and that failure to provide such information or refusal to consent to the processing of personal information may result in an unsuccessful application.
7. I further consent to the use of my personal information for the purpose of direct marketing of goods and services offered by Momentum Metropolitan Holdings Group (which includes Multiply and Multiply Money). Yes ☐ No ☐

6: Terms and conditions (continued)

For Multiply (continued)

8. I understand that I have the right to withdraw my consent to have my personal information processed and that I may contact the Multiply call centre at 0861 88 66 should I wish to cancel my Multiply membership. I acknowledge that the cancellation of Multiply does not automatically cancel my Multiply Money benefit and I understand that I will need to contact Multiply Money to cancel the benefits.
9. If I have a complaint related to the product or services received, including the processing of my personal information on the Multiply rewards programme or Multiply Money benefit, I understand that I should first refer the complaint to either Multiply by calling 0861 88 66 00 or emailing multiply@momentum.co.za or Multiply Money by calling 0860 11 11 83 or emailing multiplymoney@multiply.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. If I am not satisfied with the resolution of my complaint regarding the processing of my personal information, I understand that I may lodge my complaint with the Information Regulator at 010 023 5200 or via email at inforeg@justice.gov.za.
10. I understand that I will receive mandatory communication from Momentum 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.

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.

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 credit worthiness.
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 interest rate.

For Multiply Money Card

Please read the statements below and sign your acceptance thereof.

1. By applying for the Multiply Money Card, I am deemed to have read and understood the Terms and Conditions for Use of the card which can be accessed via the Multiply website at multiply.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. Momentum Multiply will verify my identity and residential address and they may decline to issue or activate a card if I cannot give them satisfactory proof of my identity and residential address as per the FICA (Financial Intelligence Centre Act) requirements.
3. There must be funds available in my HealthSaver account for a transaction to be authorised.
4. 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.
5. 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.
6. I can cancel my card at any time by notifying Momentum Multiply 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.
7. Momentum Multiply 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.

6: Terms and conditions (continued)

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.

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 Metropolitan Holdings Limited. To apply, please speak to your financial adviser.