momentum health

Continuation form

2018

Membership number [ ]

Existing Momentum Health members complete this form to continue your membership due to (please tick the applicable scenario):

- Dependant becoming principal member on own membership [ ]
- Member of a group becoming an individual member in the event of:

Retirement	
Medical retirement	
Early retirement	
Retrenchment	
Other (please provide details)	

- Principal member and spouse swop [ ] (Current principal member to please sign below)

  Please provide the reason for the swop ______

Signature of current principal member ______ **Date** D D – M M – 2 0 Y Y

Important notes:

- To qualify as a continuation of membership no break in your Momentum Health membership is allowed.
- Please provide a copy of ID for principal member, spouse and adult dependants.
- If a company bank account is to be deducted, section 4b may only be signed by the authorised person.
- If the continuation is due to the death of the principal member, please provide a copy of the death certificate.
- Please check with your financial adviser or call us on 0860 11 78 59 to confirm the contribution payable.
- Please submit the completed and signed form via fax to **031 580 0613** or email at **membership@momentumhealth.co.za.**

Section 1: Principal member's details

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 ______

Home address ______

Postal code ______

Postal address (if different) ______

Postal code ______

Telephone - home ______ Cellphone number ______

Email address ______

Please note that the email address you provide will be used when the Scheme communicates with you.

Section 2: Dependants

Complete the details of your dependants who will be continuing on your membership. Please note that if you do not complete the details of your dependants, their membership will be discontinued.

Please complete an Addition of Dependants form if you would like to add any dependants who are not currently covered on your membership.

First name	Surname	ID/Passport number	Country in which passport was issued	Date of birth	Gender (M/F)	Relationship to principal member
1						
2						
3						
4						
5						

Section 3: Banking details for payment of contributions

Is the contribution payer the

- Principal Member (complete only section 3.2 and 4a only. Please provide copy of ID) ☐
- Company (as per company application form – complete section 4b only) ☐
- Other (complete sections 3.1, 3.2 and 4a - please provide a copy of the principal member's and premium payers ID) ☐

Section 3.1

Title ____ Initials ____ First name ____

Surname/Name of company ____

ID/Passport number ____

Date of birth D D – M M – Y Y Y Y

Home address ____

Postal code ____

Postal address (if different) ____

Postal code ____

Telephone - work ____ Cellphone number ____

Email address ____

Section 3.2

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

(Please do not provide credit card details. Momentum Health 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 ____

Section 4a: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. Momentum Health will debit your bank account for contributions on the 1st working day of every month. I understand that Momentum Health 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.

If an **individual's** account is to be debited:

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

Signature ____ **Date** D D – M M – **2** **0** Y Y

Section 4b: Authorisation for contribution collection (continued)

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

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

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

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D – M M – 2 0 Y Y

Company stamp

Section 5: 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 and a copy of the principal member's ID.

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

If not, please complete the bank details below.

(Please do not provide credit card details. Momentum Health 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 – 2 0 Y Y

Section 6: Financial adviser (where applicable)

Do you want to continue with your current financial adviser? Yes ☐ No X

If no, please complete the details below:

Name	Financial adviser's code	Broker house code	Commission ref no
Jean le Roux | Quattro Med	091545	039999	n/a

Signature of new financial adviser

Date D D – M M – 2 0 Y Y

Section 7: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by MMI 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, retain all contributions or 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.

Section 7: Terms and conditions (continued)

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 cancellation 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,
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme may result in suspension of membership and/or handover to a third party for debt collection. Refer to point 6.
9. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, I authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other healthcare provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.
10. I acknowledge that the Scheme has the right to apply the remainder of 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 reduction of benefits payable by the Scheme for any procedure undertaken.
13. I undertake to give 30 days notice should I wish to terminate my membership.
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 MMI Group Holdings Limited.
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.**

Signed at

Effective date of continuation 0 1 – M M – 2 0 Y Y

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

Signature of principal member **Date** D D – M M – 2 0 Y Y

Momentum Health 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 www.momentumhealth.co.za
Registered in terms of the Medical Scheme Act No 131 of 1998

momentum

Application for complementary products

2018

Important notes:

- As a Momentum Health member, you can choose to make use of additional products available from Momentum Group (Momentum), a division of MMI Group Limited, to seamlessly enhance your medical aid. Please note that Momentum is not a medical scheme, and is a separate entity to Momentum Health. You can be a member of Momentum Health without taking any of the complementary products that Momentum offers.
- If you choose to take any of these products, please complete the contract details for each product you require.

Section 1: Multiply contract details

Section 1.1

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

Contributions will be calculated based on your medical aid membership composition:

- Single member R219
- Family of two R269
- Family of three or more R299

How would you like to receive your Multiply welcome pack?

Mail to member's postal address ☐	Member to collect ☐
Send to branch ☐	Financial adviser to collect ☐

Section 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.

Principal member

Passport number

Date of issue DD – MM – YYYY Expiry date DD – MM – YYYY

Country of issue

Nationality

Tax reference number

Tax residency country

Spouse or partner (if applicable)

Passport number

Date of issue DD – MM – YYYY Expiry date DD – MM – YYYY

Country of issue

Nationality

Tax reference number

Tax residency country

Section 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 %
Jean le Roux | Quattro Med	091545	039999	n/a	n/a

Signature of financial adviser **Date** DD – MM – 20YY

Signature of financial adviser **Date** DD – MM – 20YY

Section 2: HealthSaver contract details

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

Section 2.1: Free HealthSaver account

[x] Tick this box if you would like Momentum to activate your free HealthSaver account.

Section 2.2: HealthReturns

[x] Tick this box if you want your HealthReturns to be paid into your HealthSaver account.

(And be eligible for HealthReturns Booster. If you do not select this option, HealthReturns will be paid into your bank account.)

Section 2.3: Monthly HealthSaver

[ ] Tick this box if you want to start contributing to your HealthSaver and complete your chosen amount 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).

Section 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 (complete if you are applying for credit on your monthly contributions). We will use this information to carry out a credit check.

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

Section 2.5: Claims payment

In-hospital claims:

[x] 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

[x] Tick this box if you want your claims to be paid at up to a maximum of 200% of the Momentum Health Rate

Section 2.6: Multiply Visa® Card

[ ] Tick this box if you want to apply for a Multiply Visa® Card

You can apply for a maximum of 2 cards. Cardholders must be a registered dependant on the medical aid.

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

Cardholder (HealthSaver investor)

[ ] Tick this box if you want a Multiply Visa® Card

Section 2: HealthSaver contract details (continued)

Section 2.6: Multiply Visa® Card (continued)

☐ Tick this box if you want an additional Multiply Visa® Card

Additional cardholder

Title		Initials	
First name			
Surname			
Previous surname		Gender	Male ☐ Female ☐
ID number		Date of birth	DD – MM – YYYY
Passport number			
Date of issue	DD – MM – YYYY	Expiry date	DD – MM – YYYY
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 Visa® Card

Additional cardholder

Title		Initials	
First name			
Surname			
Previous surname		Gender	Male ☐ Female ☐
ID number		Date of birth	DD – MM – YYYY
Passport number			
Date of issue	DD – MM – YYYY	Expiry date	DD – MM – YYYY
Country of issue			
Nationality			
Tax reference number			
Tax residency country			
Telephone - home		Telephone - work	
Cellphone number			
Email address			

Section 3: AdviceFee contract details

Please select one of the following AdviceFee options:

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

Standard monthly amount	R43	R79	R106 x	R125	Increase option	Annual Increase x

Section 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)	☐	☐	☐

Section 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

Section 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.

If an **individual's** account is to be debited:

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

Signature of account holder **Date** D D – M M – 2 0 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 – 2 0 Y Y

Company stamp

Section 6: Terms and conditions

For protection of personal information

MMI 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.

MMI 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 MMI 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 MMI 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 MMI.
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 the MMI group of companies on its websites;
   - To provide me and my dependants' personal and health information to any other entity within the MMI Group, 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 and risk profile analysis of my and/or my dependants' products or benefits.
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 MMI 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 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, and the Pension Funds Act 24 of 1956.

Section 6: Terms and conditions (continued)

For protection of personal information (continued)

7. I understand that I have the right to request my personal information which is under the control of MMI 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 MMI 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 MMI 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 012 406 4818 or via email at inforeg@justice.gov.za.

Signature of principal member ______________ **Date** D D – M M – 2 0 Y Y

For Multiply

1. I, the principal member, hereby apply for membership of Multiply and if applicable on behalf of my dependants, which is administered by MMI Multiply (Pty) Ltd. If MMI Multiply (Pty) Ltd accepts this application, this application will serve as evidence that I agree to be bound by the rules of Multiply and undertake to adhere to such rules at all times. I may obtain a copy of the rules from the Momentum website (www.momentum.co.za/multiply) or the Multiply client contact centre on 0861 100 789.
2. I consent to paying the membership fees (where applicable) in return for the benefits supplied by Multiply to my dependants (where applicable) and me. I understand that it is my sole responsibility to ensure that MMI Multiply (Pty) Ltd receives my membership fees.
3. I acknowledge that MMI Multiply (Pty) Ltd reserves the right to cancel the membership applied for in this form if any of my dependants (who are members of the programme by virtue of this application) or I breach any of the terms and conditions of this agreement, inclusive of rules and regulations pertaining to the Multiply programme which are subject to change from time to time.
4. MMI Multiply (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally.
5. I consent that MMI Multiply (Pty) Ltd (“Multiply”) may process and retain personal information submitted by me, my financial advisor or the Multiply service provider and that this information may be shared with the Multiply service providers for the purpose of carrying out the actions for Multiply to allocate physical health and wellness points or other benefits to me in terms of my membership. I further consent to the use of my personal information for the purposes of direct marketing of Multiply’s own service. 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 against the processing of personal information. I declare that the personal information provided by me is done voluntary and that failure to provide such information or refusal to consent to the processing of my personal information may result in my membership application not being successful.

For HealthSaver

1. I am deemed to have read and understood the Rules and Conditions that apply to HealthSaver which can be accessed via the website at www.momentum.co.za/healthsaver, and consider myself bound by these Rules and Conditions. If I do not agree with the Rules and Conditions, my application cannot be processed.
2. 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 Rules and Conditions.
3. 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.

   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 R25 200.
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. I give Momentum the right to, upon the cancellation or termination of the HealthSaver product, offset any debt owing by me to Momentum Health or any Momentum product from funds available in the HealthSaver;
8. 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.
9. I understand that credit granted will be subject to a variable interest rate.

Section 6: Terms and conditions (continued)

For Multiply Visa® Card

Please read the statements below and sign your acceptance thereof.

1. By applying for the Multiply Visa® Card, I am deemed to have read and understood the Terms and Conditions for Use of the card which can be accessed via the website at www.multiply.co.za/visacard, 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. If I am a Multiply Starter member, a monthly fee of R10 is payable for the card and this fee will be debited from my HealthSaver account.
3. 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.
4. There must be funds available in my HealthSaver Account for a transaction to be authorised.
5. 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.
6. 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.
7. I can cancel my card at any time by notifying 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.
8. 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.

For AdviceFee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Health.
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 Health
   - keeping Momentum Health informed of changes in my membership details
   - informing me of changes in my contributions to Momentum Health, and
   - advising me of changes to the product and benefits that Momentum Health offers.
3. This fee may be reviewed annually when my contributions to Momentum Health are reviewed and increased by a rate based on the average contribution increase to Momentum Health. I will receive reasonable written notice of any such intended change.
4. The agreement will start when I become a member of Momentum Health, unless stated otherwise, and will end when my financial adviser is not entitled to receive compensation for my membership of Momentum Health for any reason whatsoever.
5. I acknowledge that this fee will not form part of my contribution to Momentum Health and will therefore be a separate charge.
6. I instruct MMI Group Ltd 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 – **2 0** Y Y

GapCover

Take care of shortfalls for in-hospital procedures and other healthcare related expenses not covered by your option through Momentum GapCover. Momentum GapCover is underwritten by Guardrisk Insurance Company Limited, a wholly owned subsidiary of MMI Holdings Limited. To apply, please speak to your financial adviser.

DomestiCare

With DomestiCare, your domestic worker/s can get quality healthcare cover from private doctors, dentists and optometrists. For more information on DomestiCare, or to complete the quick online registration process, please visit www.domesticare.co.za. Alternatively, you can contact us on 021 673 1800 or 0860 101 159, should you require more information or assistance with the registration process.

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
Call Centre 0860 11 78 59 member@momentumhealth.co.za www.momentumhealth.co.za
Reg. No. 1904/002186/06 Momentum, a division of MMI Group Limited, an authorised financial services and credit provider