momentum
medical scheme

Option Selection Form

2023

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 18 November 2022.** The requested changes will be effective from 1 January 2023.

Member details

Member number

Employee number

Title

Initial/s

Surname

ID number

Cellphone number

Email

Option choice

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 Network provider	☐

Income

R15 326+	☐
R10 776 - R15 325	☐
R8 151 - R10 775	☐
R826 - R8 150	☐
≤ R825	☐

*If less than R15 326, 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
- Any hospital ☐
- Associated hospitals ☐

Chronic provider
- Any ☐
- State ☐
- Associated GP and Courier Pharmacies ☐

Incentive Option ☐ **Savings: 10%**

Hospital provider
- Any hospital ☐
- Associated hospitals ☐

Chronic provider
- Any ☐
- State ☐
- Associated GP and Courier Pharmacies ☐

Extender Option ☐ **Savings: 25%**

Hospital provider
- Any hospital ☐
- Associated hospitals ☐

Chronic provider
- Any ☐
- State ☐
- 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