Broker House: Aon South Africa (Pty) Ltd
Broker House Code: 032259
Tel No: 0860 835 272

momentum
health

Application for addition of dependants

2017

Important notes:

- Momentum Health is a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Momentum Health is administered by a separate company, MMI Health (Pty) Ltd (Administrator), a division of MMI Group Limited.
- Please do not resign your dependants from their current medical scheme until you have received written notification of acceptance from Momentum Health.
- Momentum Health will only consider membership on receipt of a fully completed application form.
- Please provide the ID number and copy of ID for all additional dependants.
- Please ensure that the first name and surname of all additional dependants are completed in accordance with their ID or passport.
- Please provide certificates of membership for previous schemes, where applicable.
- Please submit the completed and signed form via fax to **031 580 0430** or email at **healthnewbusiness@momentumhealth.co.za**.

Section 1: Personal details of principal member

Membership number

First name

Surname

Cellphone number | Fax number

Email address

Correspondence to be sent to | Member | Financial Adviser | Employer group contact

Section 2: Personal details of additional dependants

Spouse or partner

Title | Initials | First name

Surname

Previous surname | Gender | Male | Female

ID/Passport number | Date of birth DD – MM – YYYY

Country in which passport was issued

Country of residence

Marital status | Single | Married | Separated | Divorced | Widowed

Telephone - home | Cellphone number

Email address

Dependants

Dependant 1

First name

Surname

ID/Passport number | Gender | Male | Female

Country in which passport was issued

Date of birth DD – MM – YYYY | Cellphone number

Email address

Relationship to principal member

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

Section 2: Personal details of additional dependants (continued)

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 — 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 — Cellphone number

Email address

Relationship to principal member

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

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 — Cellphone number

Email address

Relationship to principal member

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

Section 3: Previous medical scheme information

List each medical scheme that your dependants have been a member of (note that only medical schemes registered in South Africa apply). This information needs to be supplied for all dependants applying for membership. If more space is required, please include additional pages.

Please provide certificates of membership for previous schemes.

Name of member	Name of scheme	Membership number	Date joined yy/mm/dd	Date terminated yy/mm/dd or current

Are the details completed above the same for all dependants applying for cover? Yes / No

If no, please provide details in the space above.

Have your dependants been forced to change their medical scheme due to no longer being eligible to remain on their current scheme? Yes / No

If yes, please include a certificate of membership from their current scheme, along with proof of the forced move (such as copy of resignation letter).

Section 4: Medical details

Please make sure that you have completed Section 3 before completing this section.

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Spouse or partner

Height , m — Tobacco smoked: Quantity per day

Mass kg — Alcohol consumed: Quantity per week — Type

Section 4: Medical details (continued)

Adult dependant 1

Height	, m	Tobacco smoked	Quantity per day		
Mass	kg	Alcohol consumed	Quantity per week	Type	

Adult dependant 2

Height	, m	Tobacco smoked	Quantity per day		
Mass	kg	Alcohol consumed	Quantity per week	Type	

Adult dependant 3

Height	, m	Tobacco smoked	Quantity per day		
Mass	kg	Alcohol consumed	Quantity per week	Type	

Adult dependant 4

Height	, m	Tobacco smoked	Quantity per day		
Mass	kg	Alcohol consumed	Quantity per week	Type	

Doctor/s consulted in the past 12 months

If your family has consulted more than one doctor in the past 12 months, please list all doctors that you consulted.

Name and surname

Telephone - work | How long has he/she been your doctor (years)?

Name and surname

Telephone - work | How long has he/she been your doctor (years)?

Name and surname

Telephone - work | How long has he/she been your doctor (years)?

If any of your dependants are living with HIV/Aids.

If you would prefer not to disclose the nature of your dependants HIV-status due to confidentiality, you may wait until you have received confirmation that they have been added to your membership. On receipt of confirmation, you have 14 working days to contact LifeSense Disease Management on 0860 50 60 80 in order to notify us that your dependants are living with HIV/Aids, failing which your membership may be terminated for nondisclosure. This information will be kept confidential.

☐ Tick here to indicate that you have read the disclaimer, and that the same information has been shared with all your dependants included on the application form.

Section 4.1

Complete this section if your dependants have been a member of a medical scheme registered in South Africa for at least 24-months and less than 90 days have passed since their resignation from that scheme. If not, please complete Section 4.2.

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

In the last 12 months, have your dependants had any of the following:

4.1.1	Are your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months?	Yes	No
4.1.2	Have your dependants had an operation or admission to any hospital in the last 12 months?	Yes	No
4.1.3	Are your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months?	Yes	No
4.1.4	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by your dependants, and could potentially result in a medical claim within the next 12 month?	Yes	No
4.1.5	Is there any other condition or symptom, which is not detailed in any question above, that your dependants have experienced and for which they have not yet sought medical advice?	Yes	No

All questions must be answered with a 'Yes or 'No'. If 'Yes' to any question, please provide full details below. If more space is required please include additional pages.

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 4: Medical details (continued)

Section 4.2

Complete Section 4.2 if:

- **your dependants have not been a member of a medical scheme registered in South Africa for more than 90 days; or**
- **your dependants have been a member of a medical scheme registered in South Africa for less than 24-months and less than 90 days have passed since their resignation from that scheme.**

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

All questions must be answered with a 'Yes' or 'No'. If 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

In the last 12 months, have your dependants had any of the following:

4.2.1 **Disorders or problems with the heart or cardiovascular system.** E.g. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.2 **Respiratory or lung trouble.** E.g. tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver.** E.g. gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis,cirrhosis, liver failure, or have you ever had a gastroscopy, colonoscopy, or other special examinations? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs.** E.g. abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections, or sexually transmitted disease? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.5 **Disorders of the nervous system or brain.** E.g. epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have you or any of your dependants had or been advised to have an MRI or CT scan? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.6 **Mental disorders.** E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, post-traumatic stress disorder or substance abuse? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.7 **Ear, nose, throat or eye disorders.** E.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs or spine.** E.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint trouble, multiple sclerosis, any joint problems or replacements, acne, eczema or psoriasis? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 4: Medical details (continued)

Section 4.2 (continued)

4.2.9 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.10 **Cancer,** a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant. Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.11 Are any of your dependants currently undergoing, or anticipating any specialised dental/maxillo facial treatment? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.12 Are any of your dependants taking ongoing medication for any condition not listed in any other question? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.13 Have any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.14 Are any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.15 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by your dependants, and could potentially result in a medical claim within the next 12 months? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.16 Is there any other condition or symptom, which is not detailed in any other question, that your dependants have experienced and for which they have not yet sought medical advice? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

Questions 4.2.17 to 4.2.18 apply to female applicants

4.2.17 Have any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do any of your dependants suspect that they may be pregnant? Yes ☐ No ☐

Name of member	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.18 Are any of your dependants currently pregnant? Yes ☐ No ☐

Section 5: Terms and conditions

1. I apply for my dependants 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 to add my dependants to my 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, 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 dependants' 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 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 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 dependants' good health 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 any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 4, on pg 3).
12. I will notify the Scheme should any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. wI 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 a calendar month's 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, as Momentum Health and MMI Holdings are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants are accepted as members of the Scheme, the 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 Health confirm your dependants' start date or terms of acceptance before activation?* Yes [ ] No [ ]

* Where waiting periods and/or Late Joiner Penalties apply to your dependants' membership, you will be required to sign an acceptance letter before Momentum Health activates their membership.

Signed at ____________________

Starting date* 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

Section 6: Employer warrantee for payment of contributions

To be signed by an employer representative if the company pays your contribution.

- Momentum Health may bill us for the increased contributions 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

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