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

momentum health

Application for reinstatement of membership

2017

Membership number

Important notes:

- Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership
- Please submit the completed and signed form via fax to **031 580 0613** or email at **membership@momentumhealth.co.za.**
- If your application for reinstatement is approved, all outstanding amounts owed to the Scheme must be paid within 7 days.

Section 1: Current state of health

Completion of this section is compulsory

Have you, or any of your dependants, sought medical advice or received treatment for any condition or illness, or have you had symptoms or received treatment for any illness even if no diagnosis has been made, since the date of termination of your Momentum Health membership?

No **If No, please complete Section 2.**

Yes **If Yes, please complete Section 3.**

Section 2: No change in health

I hereby declare that there has been no change in my health, or the health of my spouse and/or dependants, since the date of termination of my Momentum Health membership.

Full name

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

Section 3: Updated health information

If there have been any changes in your, or your dependants' health status, please provide full details below:

Full name

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

Section 4: Banking details for payment of contributions

(Please do not provide credit card details. Momentum Health is not allowed to record your credit card details.)

If the principal member is not the contribution payer, please submit a copy of the contribution payer's ID.

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

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 the 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:

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.

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 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 copy of their 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

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Momentum Health 1-3 Canegate Road La Lucia Ridge 4019 PO Box 2338 Durban 4000 South Africa
Client Service and Authorisation 0860 11 78 59 member@momentumhealth.co.za www.momentumhealth.co.za

momentum

Complementary products

2017

Important note:

- 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. Membership of Momentum Health is not conditional on taking any of the complementary products that Momentum offers

Please indicate which complementary products you wish to reinstate | Multiply | | HealthSaver | | AdviceFee | | HealthWaiver | |

Section 1: Banking details for payment of contributions

Please indicate the contribution payer for each of the complementary products you wish to reinstate:

Contribution payer	Multiply	HealthSaver	AdviceFee	HealthWaiver
Principal Member				
Company (as per company application form)				

(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 2: 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 specifie

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

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