

# Continuation form

2017

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	<input type="checkbox"/>
Medical retirement	<input type="checkbox"/>
Early retirement	<input type="checkbox"/>
Retrenchment	<input type="checkbox"/>
Other (please provide details)	<input type="checkbox"/>

• Principal member and spouse swop  (Current principal member to please sign below)

Please provide the reason for the swop

<b>Signature of current principal member</b>	<input type="text"/>	<b>Date</b>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**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 3 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](mailto:membership@momentumhealth.co.za).

## Section 1: Principal member's details

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>				
Previous surname	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
ID/Passport number	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country in which passport was issued	<input type="text"/>				
Country of residence	<input type="text"/>				
Home address	<input type="text"/>				
	<input type="text"/>				
	<input type="text"/>				
Postal address (if different)	<input type="text"/>				
	<input type="text"/>				
	<input type="text"/>				
Telephone - home	<input type="text"/>	Cellphone number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>				

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



## Section 4: 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    -    - 2 0

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 copy of their ID.

(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    -    - 2 0

## Section 6: Financial adviser (where applicable)

Do you want to continue with your current financial adviser?

Yes  No

If no, please complete the details below:

Name	Financial adviser's code	Broker house code	Commission ref no
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of new financial adviser

Date    -    - 2 0

## 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.
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.



## Application for complementary products

2017

### 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
- Family of two
- Family of three or more

How would you like to receive your Multiply welcome pack?

### Section 1.2: 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  -  -

## 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

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

### Section 2.2: HealthReturns

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         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: HealthSaver contract details (continued)

### 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)

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						
<b>Net monthly income</b>	<b>R</b>						

#### 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:

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 Health Rate

## Section 3: AdviceFee contract details

#### Please select one of the following AdviceFee options:

Tick this block if you would like to include AdviceFee.

Standard monthly amount    R41    R75    R100    R119    Increase option    Annual Increase

## Section 4: HealthWaiver

### Section 4.1 Insured life/lives

Tick this block if you would like to apply for a HealthWaiver policy.

Insured life/lives    Principal member    Spouse

### Section 4.2 Contract details

Benefit payment term    5 years    10 years

Have you smoked or used any other form of tobacco in the past twelve months?

Principal member    Yes    No    Spouse    Yes    No

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Broker House Code: 032259  
Tel No: 0860 835 272

## Section 4: HealthWaiver (continued)

### Section 4.2 Contract details (continued)

#### Medical disclaimer

Have you suffered from or do you currently suffer from or take any chronic treatment for any disease, for example cancer, cardiovascular, kidney disease, stroke, HIV/Aids, respiratory, neurological or connective tissue disease?

Principal member  Yes  No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No

Spouse  Yes  No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### Exclusion for pre-existing condition

All claims arising from any physical defects, illnesses, bodily injuries or diseases that the insured life suffered from, was aware of, or has received medical treatment or advice for in the three years prior to the starting date of a qualifying benefit, are excluded for the first three years from the starting or restarting date of that benefit. If no such qualifying benefit exists, the 3-year period will apply to the starting date of this benefit. If the principal member upgrades his options under his medical aid membership or adds new dependants (except as a result of marriage or childbirth) to his medical aid membership, a new 3-year period will apply to the increase in the medical aid contribution from the date of the increase.

**Please read the clause below carefully. It contains provisions that potentially compromise your rights.**

- Any physical defect, illness, bodily injury or disease that I or my dependants suffered from, were aware of or received treatment for in the past three years is considered a pre-existing condition.
- I understand that any claim due to a pre-existing condition will not be covered for the first three years from the starting or re-starting of a qualifying benefit.
- If no such qualifying benefit exists, the three year period will apply to the starting date of this benefit.
- If I, as the principal member, upgrade my options under my medical aid membership or add new dependants (except as a result of marriage, childbirth or adoption) to my medical aid membership, a new three year period will apply to the increase in my medical aid contribution from the date of the upgrade.

**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.**

Signature of principal member	<input type="text"/>	Date	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - 2 0 Y Y
Signature of spouse	<input type="text"/>	Date	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - 2 0 Y Y

### Section 4.3 Start of policy

The starting date will depend on the starting date of your medical aid membership. This policy cannot have a starting date that is earlier than the medical aid starting date.

### Section 4.4 Replacement of insurance

Does this application replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance discontinued within the last four months or within the next four months)?  Yes  No

If Yes, the financial adviser must discuss and complete the *Replacement Policy Advice Record* (MYRIAD 013).

**Important note:** The replacement of any insurance has various potentially detrimental consequences which your financial adviser should disclose to you. **Momentum will not automatically cancel a Momentum policy/policies on acceptance, unless the client submits a conditional termination form with this application form.**

#### Declaration by the financial adviser

I hereby declare that I have requested and recorded the client's response to the above question with regard to replacement and that the client is fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I further declare that, irrespective of the client's response to the question with regard to replacement, that I have explained the following to the client:

- The meaning of replacement,
- That a replacement is potentially prejudicial, and
- That where a replacement is considered, the client is legally entitled to comprehensive information regarding the consequences of replacement.

Signature of financial adviser	<input type="text"/>	Date	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - 2 0 Y Y
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## Section 4: HealthWaiver (continued)

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### Section 4.5 Policy Holder details

Name of legal entity	<input type="text"/>																								
Contact person in case of legal entity	<input type="text"/>																								
Registration number	<input type="text"/>												Registration date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Postal address	<input type="text"/>																								
	<input type="text"/>																								
	<input type="text"/>																								
Telephone - work	<input type="text"/>						<input type="text"/>						Fax number	<input type="text"/>			<input type="text"/>								
Cellphone number	<input type="text"/>			<input type="text"/>						<input type="text"/>															
Email address	<input type="text"/>																								
Preferred method of communication	Email <input type="checkbox"/>			Post <input type="checkbox"/>																					
Tax status	Company / Close Corporation (M) <input type="checkbox"/>						Natural persons (N) <input type="checkbox"/>						Non-taxable institution (I) <input type="checkbox"/>												
Tax status of trust beneficiaries if the applicant is a trust company	Company (C) <input type="checkbox"/>						Natural persons (P) <input type="checkbox"/>						Non-taxable institution (Z) <input type="checkbox"/>												

## Section 5: Banking details for payment of contributions

Please indicate the contribution payer for each of the complementary products applied for:

Contribution payer	Multiply	HealthSaver	AdviceFee	HealthWaiver
Principal Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Company (as per company application form)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Name of account holder	<input type="text"/>																							
Name of bank	<input type="text"/>																							
Account number	<input type="text"/>																							
Account type	Current/Cheque <input type="checkbox"/>						Savings <input type="checkbox"/>						Transmission <input type="checkbox"/>											
Branch code	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	Branch name	<input type="text"/>															

## Section 6: 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	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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	<input type="text"/>																							
Position in company	<input type="text"/>																							

Signature of account holder/ Authorised signatory	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>											
Company stamp	<input type="text"/>																						



## Section 7: Terms and conditions

### For protection of personal information

MMI comprises companies that provide the following products and services:

- financial planning services, healthcare administration, insurance products, investment products, managed care services and retirement benefits.

MMI is committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. To deliver an integrated value proposition across all the products available from MMI, we need your consent to share your and your child and adult dependants' personal information between the subsidiaries of MMI and contracted third parties both locally and outside the Republic of South Africa who require this information.

1. You confirm that you are authorised to provide consent in this section on behalf of your dependants.
2. You authorise and give consent to MMI to process, further process and share your personal information, including health information, and that of your dependants, for purposes of any products and services with the subsidiaries of MMI.
3. The personal information will be shared to provide for the following purposes:
  - to interact with, and view all the products and services you have with the MMI group of companies on its websites,
  - to provide your and your dependants' personal and health information to any other entity within the MMI Group, where you and/or your dependants already have a relationship or where you and/or your dependants have applied for a product or benefit, for the administration, underwriting and risk profile analysis of you and/or my dependants' products or benefits.

### Declaration

I am aware that I may withdraw my permission given above to share my and/or my dependants' information with MMI and its subsidiaries, except if the disclosure thereof is necessary for the administration of the product or services provided or is required in terms of legislation or to give effect to the implementation of an agreement for my or any of my dependants' benefit.

Signature of principal member

Date    -    -

### 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](http://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 voluntarily 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 agree to be bound by the Rules and Conditions that apply to the HealthSaver and the terms and conditions of the loan agreement as set down in the Rules and Conditions.
2. I have been provided with a copy of the Rules and Conditions and I have been given an opportunity to consider, familiarise myself with and agree to the Rules and Conditions.
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 Rules 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.

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.

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

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## Section 7: Terms and conditions (continued)

### 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 R24 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. 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.

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### 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.

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### For HealthWaiver

I accept and understand that I am limiting my right to privacy. However, to enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits under this or any other application for insurance that I have made or that was made for me as the insured life, I authorise the MMI Group Limited, a registered long-term insurer, including the current and future subsidiaries and/or representatives (Momentum):

- to obtain from any person, including Momentum Health and their administrators, any information that Momentum needs in connection with this application or the policy. I also authorise and instruct such person to give the said information to Momentum, and
- to share with other insurers that information and any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

1. This document and any documents that were submitted in connection with it form the basis of the contract I intend entering into, and all information that I have supplied is correct and complete.
2. I undertake to let Momentum know in writing if a change takes place in the health of the insured life/lives between the date of this application and the starting date of the policy or the acceptance date, whichever occurs last.
3. Only the conditions in the contract will bind Momentum and not the representations or undertakings that any person makes or gives.
4. I consent that Momentum may inform anyone who later owns this policy if Momentum adjusts the benefits or the premium under this policy for any reason.
5. I understand that Momentum will cancel the insurance contract that it has issued under this application if the insured life/lives has/have withheld any material information on this application form, or answered any question/s incorrectly, and that the policyholder will forfeit all premiums that he/she paid.
6. I understand that I may cancel this contract within 30 days of the date of the letter of acceptance. I also understand that if I use this right, Momentum will pay back all premiums that I have paid, after Momentum has deducted the cost of any benefits I have enjoyed, the cost of any investment and/or currency risk exposure, and certain expenses.
7. I acknowledge that I have read the valid and official quotation that Momentum has issued that sets out the policy benefits for which I have applied in the properly completed policy application. I confirm that my authorised financial adviser has explained the contents of the quotation to me and I agree that the details set out in it will bind me.
8. I acknowledge and understand that the MMI Group Limited and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain if I sign this application before completing it in full. I acknowledge and understand that it is an offence to sign a blank or incomplete application form, as stated in the Policyholder Protection Rules that have been published under the Longterm Insurance Act 52 of 1998.

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## Section 7: Terms and conditions (continued)

### For HealthWaiver (continued)

- I am aware that any information provided for the purpose of this application is subject to the stipulations of the Financial Intelligence Centre Act 38 of 2001 and that it will be dealt with in accordance with requirements that the Act contains.
  - I acknowledge that I have read the declaration above, that I fully understand the nature and effect of it and that it will bind me.
  - I accept all legal risks associated with communicating with Momentum via the electronic medium that I chose in this communication, and I indemnify and hold Momentum harmless against any consequent loss that I or any third party may suffer as a result of the misuse, misapplication, or misinterpretation of this communication. In the event of a conflict between the contents of this communication and any subsequent written instruction of the policyholder, this communication will take precedence, and will be binding on the policyholder, provided that this communication has been properly completed and is regular on the face of the document.
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Sign here to accept the terms and conditions relevant to the complementary products you are applying for.

Signed at

Signature of principal member

Date    -    - 2 0

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### 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.

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### 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](http://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.

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

Contact us on: **0860 tel arc / 0860 835 272**, P.O. Box 1874, Parklands, 2121, [www.aon.co.za](http://www.aon.co.za)  
 FSB number: 20555; CMS number: ORG895

## Acknowledgement of appointment

I hereby authorise Aon South Africa (Pty) Ltd to be my duly appointed Broker with immediate effect.

My ID  and membership number

I have also been informed that the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT).

Signed at (town or city)  on yy/mm/dd

Signature

## Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number

Medical Scheme  Aon Broker Code

Title  Initials  Surname

First name(s) (as per identity document)

ID or passport number

To clarify this, the following information will be made available:

Personal examples	Benefit examples	Financial examples	Medical examples
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon South Africa (Pty) Ltd to provide me with any products that they consider appropriate to me.

Yes  No

Signed at (town or city)  on yy/mm/dd

Signature