

Option Selection Form

2018

Important notes:

- You only need to complete this form if you want to change your current option and/or choice of provider. Please ensure 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 this form, fully completed, to your HR or Payroll department.
- If you are an individual member, please fax this form, fully completed, to the Momentum Health membership department on **0860 77 55 66** or email it to **mhmembership@momentum.co.za**.
- Please ensure that this form reaches Momentum Health by no later than 23 November 2017. The requested changes will be effective from 1 January 2018.

Member details

Member number	<input type="text"/>	Employee number	<input type="text"/>
Title	<input type="text"/> Initial/s <input type="text"/>	Surname	<input type="text"/>
ID number	<input type="text"/>	Cellphone number	<input type="text"/>
Email	<input type="text"/>		

Ingwe Option <input type="checkbox"/>	Hospital provider	Chronic and Day-to-day provider	Income
	State hospitals	Ingwe Primary Care Network provider	R11 701 +
	Ingwe Network	Ingwe Primary Care Network provider	R8 501 - R11 700
	Any hospital	Ingwe Active Primary Care Network provider	R6 301 - R8 500
			R676 - R6 300
			≤ R675
Provider's practice number	<input type="text"/>		
Provider's practice name	<input type="text"/>		

*If less than R11 701, please complete the Declaration of Income

Impact Option <input type="checkbox"/>	Hospital provider	Day-to-day provider	Chronic provider	Income
	Impact Network	Impact Primary Care Network	State	R11 701+
				R8 501 - R11 700
				≤ R8 500
Provider's practice number	<input type="text"/>			
Provider's practice name	<input type="text"/>			

*If less than R11 701, please complete the Declaration of Income

Access Option <input type="checkbox"/>	Hospital provider	Chronic and Day-to-day provider	Income
	Access Network	Access Primary Care Network	R11 701 +
			R8 501 - R11 700
			≤ R8 500
Provider's practice number	<input type="text"/>		
Provider's practice name	<input type="text"/>		

*If less than R11 701, please complete the Declaration of Income

Custom Option <input type="checkbox"/>	Hospital provider	Chronic provider
	Any hospital <input type="text"/>	Any <input type="text"/> State <input type="text"/>
	Associated hospitals <input type="text"/>	Associated GP and Courier Pharmacies <input type="text"/>

Incentive Option <input type="checkbox"/>	Hospital provider	Chronic provider	Savings: 10%
	Any hospital <input type="text"/>	Any <input type="text"/> State <input type="text"/>	
	Associated hospitals <input type="text"/>	Associated GP and Courier Pharmacies <input type="text"/>	

Extender Option <input type="checkbox"/>	Hospital provider	Chronic provider	Savings: 25%
	Any hospital <input type="text"/>	Any <input type="text"/> State <input type="text"/>	
	Associated hospitals <input type="text"/>	Associated GP and Courier Pharmacies <input type="text"/>	

How would you like us to pay your day-to-day claims? At the claims accumulation rate At up to 200% of the Momentum Health Rate

Summit Option <input type="checkbox"/>	Hospital provider Any	Chronic and Day-to-day provider Freedom-of-choice
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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 - -

Employer approval (to be completed if your employer pays your contributions)

Name

Designation

Signature of authorised person

Date - -

Employer stamp

Declaration of Income

2018

Membership number

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This form needs to be completed if you are a member of, or if you wish to join the Ingwe, Impact or Access Option.

On the Ingwe, Impact and Access Options, the higher of your or your spouse/partner's gross income is used to calculate the contributions you pay.

To calculate your contributions, we define income as any amount received by or payable to you, your spouse or partner (if he/she is included on your membership), including, but not limited to, the following:

- the average of your past twelve months' salary, commission or rewards from employment or self-employment (whether this employment is in the formal or informal sector);
- any amounts you receive from the provision of services and/or goods;
- all interest and dividend income you receive;
- any amounts you receive from leasing of assets or property;
- any payments you receive from a pension fund, provident fund, retirement annuity or annuity;
- any amounts you receive from a trust;
- any amounts received from social assistance programmes;
- any other income received.

We will need proof of your income (see Section 1).

Please submit the completed form and supporting documents to us via email at mhmembership@momentum.co.za or fax to **0860 77 55 66**.

Section 1: Proof of income

Please provide us with the following documents as proof of income (please note that the documents are required for you and your spouse or partner if he/she is included on your membership):

- If employed, your latest payslip or IRP5 certificate. If you earn a variable income please provide us with your last 3 months' payslips.
- If self-employed, copies of the latest current audited financial statements of your company and the last 3 months' bank statements for you and your company.
- If unemployed, your last 3 months' bank statements including an affidavit confirming unemployment.
- If a pensioner, proof of annuity or pension income (a letter from SASSA will be accepted) and your last 3 months' bank statements.

Section 2: Employment status and income

Please confirm the employment status and gross monthly income for you and your spouse or partner if he/she is included on your membership.

Principal member

Employment status	Employed	Unemployed	Self-employed	Pensioner																				
Monthly income	R <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																							

Spouse or partner

Employment status	Employed	Unemployed	Self-employed	Pensioner																				
Monthly income	R <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																							

Section 3: Declaration

I confirm that all the information supplied here is true and correct.

I understand that should I make a false declaration, this may lead to termination of my Momentum Health membership.

Signature of principal member

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Date

D	D	-	M	M	-	2	0	Y	Y
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