momentum
health

Application for membership for South African Cricketers' Association

Includes HealthSaver and Multiply

2012

Important notes:

- Please do not resign from your 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 a copy of ID for principal member, spouse and adult dependants.
- FICA requirements for HealthSaver: Certified proof of identification and certified proof of residential address (not older than 3 months)
- If your employer is not already registered as a group on Momentum Health, a company application form needs to be completed.

Section 1: Personal details

Principal member

Title | Initials | First name

Surname

Previous surname

ID/Passport number*
*If passport number, please supply date of birth
(Y Y M M D D) | Gender: Male | Female

Country in which passport was issued

Country of residence | Marital status

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

Email address

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

Spouse or partner (If spouse or partner is also applying for membership)

Title | Initials | First name

Surname

Previous surname

ID/Passport number*
*If passport number, please supply date of birth
(Y Y M M D D) | Gender: Male | Female

Country in which passport was issued

Country of residence | Marital status

Telephone - home (code - number) | Cellphone number

Email address

Dependants (If dependants are also applying for membership)

Dependant 1

First name

Surname

ID/Passport number*
*If passport number, please supply date of birth
(Y Y M M D D) | 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 1: Personal details (continued)

Dependant 2

First name

Surname

ID/Passport number*
*If passport number, please supply date of birth
Y Y M M D D 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*
*If passport number, please supply date of birth
Y Y M M D D 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*
*If passport number, please supply date of birth
Y Y M M D D 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 2: Franchise information

Franchise Name Saca Management (PTY) LTD

Existing group number 1153711701 5

Business telephone number (code - number)

Contract start date D D – M M – Y Y Y Y

Section 3: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %
Gary Feldman	620417	033599		100 %

Signature of financial adviser

Date D D – M M – 2 0 Y Y

How would you like to receive your welcome pack? Mail to member ☐ Send to branch ☐ Other (please specify) _____

Section 4: Marketing adviser (where applicable)

Name: E l l e n G r a y

Marketing adviser's code: 6 0 7 4

Branch name

Telephone - work (code - number)

Email address

Section 5: Option choice

Important note: The principal member may make changes only on 1 January each year.

Custom Option ☐

Hospital provider	Chronic and Day-to-day provider
Any hospital ☐	Any ☐
Associated hospitals ☐	Associated GP and Courier Pharmacies ☐
	State ☐

Incentive Option ☐ **Savings:10%**

Hospital provider	Chronic and Day-to-day provider
Any hospital ☐	Any ☐
Associated hospitals ☐	Associated GP and Courier Pharmacies ☐
	State ☐

Extender Option ☐ **Savings:25%**

Hospital provider	Chronic and Day-to-day provider
Any hospital ☐	Any ☐
Associated hospitals ☐	Associated GP and Courier Pharmacies ☐
	State ☐

Pay day-to-day claims at: Accumulation rate ☐ Up to 200% of the Momentum Health Rate ☐

Section 6: Franchise warranty for payment of contributions

- I / we warrant that the principal member referred to in this application is a contracted player of our organisation.
- Momentum Health may bill us for the amount due for this member in the same manner as for other players in our organisation

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D – M M – 2 0 Y Y

Company Stamp

Section 7: Banking details for claim refunds payable to member

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

Name of account holder

Name of institution

Account number

Account type: Current ☐ Savings ☐ Transmission ☐

Branch code: Branch name:

Signature of principal member

Date D D – M M – 2 0 Y Y

Section 8: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by Momentum Medical Scheme Administrators (MMSA) (the 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, it will make any contracts to which this application relates null and void. I will also forfeit all contributions that I paid to the Scheme. In such an event the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on behalf of me or my dependants under such contracts.

3. I will notify the Scheme if any alteration takes place in any circumstances on which the Scheme based its assessment of its risk after the date of this application and before the date of the Scheme's acceptance of the risk. I acknowledge that failure to do so will make any contracts to which this application relates null and void. 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 contracts.

4. I understand that this application form is valid for 30 days only.

5. I am aware that the Scheme may ask for proof of identification at any stage.

6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contribution.
   - Non-receipt of a single month's contribution will result in suspension of medical scheme benefits. This suspension will last until I have paid all contributions in arrears.
   - Non-receipt of two months' contributions will result in cancellation of my membership of the Scheme.

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 may result in suspension of membership and/or handover to a third party for debt collection.

9. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Scheme, my answers on this form will form the basis of my membership.

10. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.

11. In the case of new members of the Scheme, the following may apply:
    - A three-month general waiting period;
    - A twelve-month exclusion on a pre-existing condition; and/or
    - Late-joiner contribution penalty.

12. I will notify the Scheme if I or any of my dependants are living with HIV/Aids.

13. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.

14. I undertake to give 30 days notice should I wish to terminate my membership.

15. I understand that if I have selected the Ingwe or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.

16. 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.

Section 8: Terms and conditions (continued)

17. Words used in this application have the meaning that the Rules give them.

18. 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.

19. I acknowledge that my 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.

Should Momentum Health confirm your start date or terms of acceptance before activation?* Yes [ ] No [ ]

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

Signed at

Starting date 0 1 – M M – 2 0 Y Y

Signature of principal member

Date D D – M M – 2 0 Y Y

The HealthSaver is a free product available to all Momentum Health members. We need your consent to activate your HealthSaver account. (See page 6)

momentum

Annexure for complementary products

2012

Important notes:

- Momentum Health members may add any of these complementary products.
- You need to complete the contract details for each product required.
- We will use the personal details completed for Momentum Health for this contract
- FICA requirements for HealthSaver: Certified proof of identification and certified sproof of residential address (not older than 3 months)

Product Selection:

Please indicate which Complementary products you are applying for, complete relevant sections and sign page 8.

HealthSaver ☐

Multiply ☐

Section 1: Fica Declaration

I confirm that I have identified the client, including the investor and contribution payer, where applicable, and verified his/her/their details on this contract under the requirements that section 21 of the Financial Intelligence Centre Act, No 38 of 2001, sets out. I further confirm that in terms of section 22 of the same Act (effective from 1 July 2003) I have stored all the verification documents

Signature of financial adviser

Date D D – M M – 2 0 Y Y

Section 2: HealthSaver contract details

Section 2.1: Free HealthSaver account

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

You can use this account as you see fit to make provision for additional healthcare expenses
If you do not wish to start contributing to HealthSaver at this point, complete Section 2.1 and Section 6.

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 the same account that Momentum Health uses to refund your claims).

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: **R** 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 2.4: 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**
Net monthly income:	**R**

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:	Momentum Group Limited
Physical Address:	268 West Avenue Centurion Gauteng 0157
Contact number	0860 11 78 59 Weekdays 08:00 to 17:00

Section 3: Multiply Contract details

Contributions will be calculated based on the membership composition of Momentum Health:

- Single member
- Family of two
- Family of three or more

How would you like to receive your welcome pack?

Mail ☐ Client collect ☐ Branch ☐ Broker collect ☐

Name of previous lifestyle programme

Previous lifestyle programme status (Please provide proof of status with the most recent statement not older than 1 month)

Section 4: Contribution payer information

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

If different account details required per complementary product, please make a copy of the annexure and attach to this application form

Is the contribution payer the:

- Principal Member (complete only section 6.2) ☐
- Company (as per company application form – ignore sections 6.1 and 6.2) ☐
- Other (complete sections 6.1 and 6.2) ☐

Section 4.1

Title | Initials | First name

Surname /Name of company

ID/Passport number | Gender: Male ☐ Female ☐

RSA ID: Yes ☐ No ☐ | Date of Birth (Y Y Y Y M M D D)

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

Email address

Section 4.2

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

Name of account holder

Name of institution

Account number

Account type: Current ☐ Savings ☐ Transmission ☐

Branch code | Branch name

Section 5: Authorisation for contribution collection

Completion of this section is complusory 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 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

D D – M M – 2 0 Y Y

Section 6: Terms and conditions

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 with FNB Corporate.
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. It is my responsibility to ensure that Momentum executes the instruction provided in this document, except where there may be a right of recovery against Momentum
   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.

Credit granting for applications

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 R18 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 when necessary.
6. I understand that credit granted will be subject to a variable interest rate.

For Multiply

1. I, the principal member, hereby apply for my dependants (where applicable) and me to become members of Multiply, which is administered by Momentum Interactive (Pty) Ltd. If Momentum Interactive (Pty) Ltd accepts this application then 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) or the Multiply client contact centre at 0861 88 66 00.
2. I consent to paying the monthly contributions in return for the benefits supplied by Multiply to my dependants (where applicable) and myself. I understand that it is my sole responsibility to ensure that my monthly contributions are received by Momentum Interactive (Pty) Ltd.
3. I acknowledge that Momentum Interactive (Pty) Ltd reserves and shall have the right to cancel the membership applied for herein if I or any of my dependants (that are members of the programme by virtue of this application) breach any of the terms and conditions of this agreement inclusive of rules and regulations pertaining to the Multiply programme in force from time to time.
4. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally from time to time, but shall inform members of any such amendments. I understand that I may cancel my participation on Multiply at any time, including when I do not accept the amended rules and benefits.

Signed at

Signature of principal member

Date D D – M M – 2 0 Y Y

268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
Client Service and Authorisation 0860 11 78 59 member@momentumhealth.co.za