momentum
medical scheme

# Option Selection Form

**2021**

**Important notes:**

- You only need to complete this form if you want to change your current option and/or choice of provider. Please make sure 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 the fully completed form to your HR or Payroll department.
- If you are an individual member, please send the fully completed form to the Momentum Medical Scheme membership department via email at **mhmembership@momentum.co.za**.
- Please make sure that this form reaches Momentum Medical Scheme by **no later than 20 November 2020.** The requested changes will be effective from 1 January 2021.

## Member details

Member number | Employee number

Title | Initial/s | Surname

ID number | Cellphone number

Email

**Ingwe Option**

| Hospital provider | Chronic and Day-to-day provider |
|---|---|
| State hospitals | Ingwe Primary Care Network provider |
| Ingwe Network | Ingwe Primary Care Network provider |
| Any hospital | Ingwe Active Primary Care Network provider |

**Income**

- R14 051+
- R9 851 - R14 050
- R7 451 – R9 850
- R751 – R7 450
- ≤ R750

*If less than R14 051, please complete the **Declaration of Income**

GP's practice number

GP's name

**Evolve Option** — **Hospital provider** Evolve Network — **Chronic provider** State

**Custom Option**

| Hospital provider | Chronic provider | |
|---|---|---|
| Any hospital | Any | State |
| Associated hospitals | Associated GP and Courier Pharmacies | |

**Incentive Option** — **Savings: 10%**

| Hospital provider | Chronic provider | |
|---|---|---|
| Any hospital | Any | State |
| Associated hospitals | Associated GP and Courier Pharmacies | |

**Extender Option** — **Savings: 25%**

| Hospital provider | Chronic provider | |
|---|---|---|
| Any hospital | Any | State |
| Associated hospitals | Associated GP and Courier Pharmacies | |

How would you like us to pay your day-to-day claims?

- At the claims accumulation rate
- At up to 200% of the Momentum Medical Scheme Rate

**Summit Option** — **Hospital provider** Any — **Chronic and Day-to-day provider** Freedom-of-choice

## 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** D D M M Y Y Y Y

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

Name

Designation

**Signature of authorised person** **Date** D D M M Y Y Y Y

**Employer stamp**

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