momentum
medical scheme

Broker House: Aon South Africa (Pty) Ltd
Broker House Code: 032259
Tel No: 0860 100 404

Option Selection Form

2025

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 29 November 2024.** The requested changes will be effective from 1 January 2025.
- Momentum Medical Scheme's 2025 benefit and contribution amendments have been submitted to the Council for Medical Schemes and are subject to approval by the Regulator.

Member details

Member number | Employee number
Title | Initial/s | Surname
ID number | Cellphone number
Email

Option choice

Ingwe Option

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

Income

R22 401+ | R17 001 - R22 400 | R11 951 - R17 000 | R9 001 - R11 950
R1 501 - R9 000 | ≤ R1500

*If less than R22 401, 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 Scheme 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

Momentum Medical Scheme 201 uMhlanga Ridge Boulevard Cornubia 4339 PO Box 2338 Durban 4000 South Africa
Client Service and Authorisation 0860 11 78 59 member@momentumhealth.co.za momentummedicalscheme.co.za
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