momentum
medical scheme

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

Change of principal member form

2024

Membership number

Existing Momentum Medical Scheme members complete this form to change the principal member due to (please tick the applicable scenario):

- Principal member and spouse swop ☐ (Current principal member and new principal member to sign below)

  Please provide the reason for the swop

Signature of current principal member **Date** D D M M Y Y Y Y

Signature of new principal member **Date** D D M M Y Y Y Y

- Continuation of spouse due to the death of the principal member ☐ (Spouse to sign below)

Signature of spouse **Date** D D M M Y Y Y Y

Important notes:

- To qualify for a continuation of membership, no break in your Momentum Medical Scheme membership is allowed.
- Please provide a copy of ID for principal member, spouse and adult dependants.
- It is compulsory to provide contact details for all dependants who are 18 or older. The Scheme will use the email addresses you provide when communicating with you and your dependants.
- If contributions will be deducted from a company bank account, section 4b may only be signed by the authorised person.
- If the continuation is due to the death of the principal member, **please provide copies of the death certificate and letters of Executorship, as well as proof of the Estate's banking details.**
- Please check with your financial adviser or call us on **0860 11 78 59** to confirm the contribution payable.
- Please email the completed and signed forms to us at **membership@momentumhealth.co.za.**

1: New principal member's details

Title | Initials | First name

Surname

Previous surname | Gender Male ☐ Female ☐

ID/Passport number | Date of birth D D M M Y Y Y Y

Country in which passport was issued

Country of residence

Home address

Postal code

Postal address (if different)

Postal code

Telephone - home | Cellphone number

Email address

2: Dependant's details

Complete the details of your dependants who will be continuing on your membership. Please note that if you do not complete the details of your dependants, their membership will be discontinued.

Please complete an Addition of Dependants form if you would like to add any dependants who are not currently covered on your membership.

2.1 Spouse or partner

Title | Initials | First name

Surname

Previous surname | Gender: Male ☐ Female ☐

ID/Passport number | Date of birth: D D M M Y Y Y Y

Country in which passport was issued

Country of residence

Marital status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Are the spouse or partner's contact details the same as the principal member's? Yes ☐ No ☐

If no, please complete the spouse or partner's details:

Home address

Postal code

Postal address (if different)

Postal code

Telephone - home | Cellphone number

Email address

2.2 Dependants

Dependant 1

First name

Surname

ID/Passport number | Gender: Male ☐ Female ☐

Country in which passport was issued | Date of birth: D D M M Y Y Y Y

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ☐ No ☐ Dependant's monthly income R

It is compulsory to provide contact details if the dependant is 18 or older.

Are the dependant's contact details the same as the principal member's? Yes ☐ No ☐

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Cellphone number

Email address

Dependant 2

First name

Surname

ID/Passport number | Gender: Male ☐ Female ☐

Country in which passport was issued | Date of birth: D D M M Y Y Y Y

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ☐ No ☐ Dependant's monthly income R

It is compulsory to provide contact details if the dependant is 18 or older.

2: Dependant's details (continued)

2.2 Dependants (continued)

Dependant 2

Are the dependant's contact details the same as the principal member's? Yes ☐ No ☐

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Cellphone number

Email address

Dependant 3

First name

Surname

ID/Passport number Gender Male ☐ Female ☐

Country in which passport was issued Date of birth D D M M Y Y Y Y

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ☐ No ☐ Dependant's monthly income R

It is compulsory to provide contact details if the dependant is 18 or older.

Are the dependant's contact details the same as the principal member's? Yes ☐ No ☐

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Cellphone number

Email address

Dependant 4

First name

Surname

ID/Passport number Gender Male ☐ Female ☐

Country in which passport was issued Date of birth D D M M Y Y Y Y

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ☐ No ☐ Dependant's monthly income R

It is compulsory to provide contact details if the dependant is 18 or older.

Are the dependant's contact details the same as the principal member's? Yes ☐ No ☐

If no, please complete the dependant's details:

Home address

Postal code

Postal address (if different)

Postal code

Cellphone number

Email address

3: Banking details for payment of contributions

Is the contribution payer the

New principal member (complete sections 3.2 and 4a only. Please provide a copy of your ID)	☐
Company (as per company application form – complete sections 3.1, 3.2 and 4b)	☐
Other (complete sections 3.1, 3.2 and 4a - please provide a copy of your ID and the premium payer's ID)	☐

3: Banking details for payment of contributions (continued)

3.1

Title		Initials	First name
Surname/Name of company			
ID/Passport number		Date of birth	D D M M Y Y Y Y
Home address			
		Postal code	
Postal address (if different)			
		Postal code	
Telephone - work		Cellphone number	
Email address			

3.2

You do not need to complete this section if your employer is paying for your Momentum Medical Scheme contributions (as per the company application form).

(Please do not provide credit card details. Momentum Medical Scheme 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	
Start date	0 1 M M Y Y Y Y		

Notes:

- The deduction date is the first working day of the month.
- The abbreviated name as registered with the bank, which will reflect on your bank statement, is MOMMEDSCH followed by your group number.

4a: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Medical Scheme may debit the above account with the amount due under the contract in accordance with the Momentum Medical Scheme debit order system. Momentum Medical Scheme will debit the bank account for contributions on the 1st working day of every month. I understand that Momentum Medical Scheme bills for contributions in advance and dependent on my commencement and activation dates there may be more than a single contribution payable to the Scheme. I may cancel this mandate and pay via other methods within 30 days. If I cancel this mandate, I remain responsible to pay any amounts due to Momentum Medical Scheme while it was in force.

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.

*Consent from third party:

I (name and surname)	
ID number	

consent to Momentum Medical Scheme deducting the contributions due for this member from my bank account.

Signature of principal member or third party (if applicable)		**Date**	D D M M Y Y Y Y

4b: 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 Medical Scheme 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 Medical Scheme.

Name

Position in company

Signature of account holder/ Authorised signatory

Date D D M M Y Y Y Y

Company stamp/letterhead

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.

☐ Tick this box if we may use the same bank account details provided for your Momentum Medical Scheme contribution payments.

If not, please complete the bank details below.

(Please do not provide credit card details. Momentum Medical Scheme 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 D D M M Y Y Y Y

6: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no

Signature of financial adviser

Date D D M M Y Y Y Y

7: Consent for Momentum Medical Scheme to process personal information

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Momentum Medical Scheme.

Momentum Medical Scheme and the Administrator, Momentum Health Solutions (Pty) Ltd, part of Momentum Metropolitan Holdings Limited, will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Momentum Medical Scheme will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I confirm that I am authorised to provide consent on behalf of my dependants and that I have their permission to share such information with Momentum Medical Scheme and the Administrator. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and I have the authority to give consent for them.
2. I declare that all my personal information and that of my dependants supplied to Momentum Medical Scheme and the Administrator is accurate, up to date, not misleading and that it is complete in all respects and will be held and/or stored securely for the purpose for which it was collected and that I will immediately advise Momentum Medical Scheme and the Administrator of any changes to my personal information and that of my dependants should any of these details change.

7: Consent for Momentum Medical Scheme to process personal information (continued)

3. I authorise, and give consent to Momentum Medical Scheme and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Momentum Medical Scheme membership risk profiling and management, administration of my membership and as set out in this section.
4. If I have consented to the disclosure of my personal information to any other entity or person (person means any natural or juristic person, firm, company, corporation, state, agency or organisation of a state, association, trust or partnership, whether or not having legal personality) or if a contractual relationship exists between Momentum Medical Scheme or the Administrator which requires Momentum Medical Scheme or the Administrator to provide my personal information to any other person, Momentum Medical Scheme or the Administrator may do so.
5. I acknowledge that I must give Momentum Medical Scheme and the Administrator all information and evidence they may require from time to time. I authorise Momentum Medical Scheme and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Momentum Medical Scheme may require concerning me or any of my dependants in assessing any risk or claim in relation to this application, my membership of Momentum Medical Scheme and risk profiling or management. I consent to that person providing, and instruct that person to provide, Momentum Medical Scheme and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
6. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
7. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
8. I have the right to request my personal information which is in the possession of Momentum Medical Scheme and the Administrator, provided that I furnish adequate identification.
9. I have the right to request Momentum Medical Scheme and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
10. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Scheme to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 010 023 5207 or via email at POPIAComplaints@inforegulator.org.za.
11. I hereby authorise, and give consent to Momentum Medical Scheme and the Administrator to share my personal information, including health information, and that of my dependants, with Momentum Metropolitan Holdings and its subsidiaries, with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity, including contracted third parties both locally and outside the Republic of South Africa who require this information. This personal information will be processed and/or used for further processing in order to:
    - administer the products or services;
    - grant me and/or my dependants, where applicable, access to interact with Momentum Medical Scheme on its website, to obtain a single view of my products with Momentum Metropolitan Holdings Limited and for purposes of receiving any reports or statements including consolidated reporting; and
    - to provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
12. I (insert name and surname) _____

    hereby give my consent to Momentum Medical Scheme's Administrator, for me to receive direct marketing of complementary products and services, insurance, investments, health insurance, retirement benefits, other financial services and health related products by Momentum Metropolitan Holdings Limited and its subsidiaries, to be marketed to me by means of electronic communication. Tick here if you do not wish to receive any direct marketing. ☐
13. You can access the full privacy policy at https://momentummedicalscheme.co.za/privacy-policy/.

Signature of principal member _____ **Date** D D M M Y Y Y Y

8: Terms and conditions

1. I apply for my dependants and I to join Momentum Medical Scheme (the Scheme) administered by Momentum Health Solutions (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, 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.

8: Terms and conditions (continued)

6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contributions as well as any other amounts I owe to the Scheme.
   - Non-receipt of contributions will result in suspension of medical scheme benefits for my entire contract. This suspension will last until I have paid all outstanding contributions.
     – I understand that whilst my contract is suspended, the Scheme will not honour any claims related to services rendered for the period that the membership is suspended.
     – I understand that I will remain fully liable to pay contributions for the period of suspension.
   - Non-payment of more than one month's contribution will result in termination of my membership of the Scheme.
   - Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection.
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 will result in suspension and eventually termination of membership and handover to a third party for debt collection. Refer to point 6.
9. I realise that I must submit evidence of my own health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that existed for a period of up to twelve (12) months prior to my application to join the Scheme.
10. I acknowledge that the Scheme has the right to apply a three-month general waiting period, a twelve-month exclusion on a pre-existing condition, and/or Late-joiner contribution penalty, where applicable.
11. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership.
12. 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 co-payment being applied as contained in the Scheme Rules.
13. I undertake to give a calendar month's notice should I wish to terminate my membership and/or terminate the membership of my dependants.
14. 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.
15. Words used in this application have the meaning that the Rules give them.
16. 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.
17. I acknowledge that my duly appointed 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.
18. I understand that I need to provide full and complete information, even if I have already done so for other policies held with any of the subsidiaries of Momentum Metropolitan Holdings Limited, as Momentum Medical Scheme and Momentum Metropolitan Holdings Limited are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants and I are accepted as members of the Scheme, my answers on this application will form the basis of our membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser, or any other third party on my behalf.**

Should Momentum Medical Scheme 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 Medical Scheme activates your membership.

Signed at

Start date* **0 1** M M Y Y Y Y

* Remember to inform us should any information provided on this form change between the date of signing the form and the start date.

Signature of principal member **Date** D D M M Y Y Y Y

momentum

Transfer of complementary products

2024

Important notes:

- You may choose to make use of additional products available from Momentum Metropolitan Holdings Limited (Momentum), to seamlessly enhance your medical aid. Momentum is not a medical scheme, and is a separate entity to Momentum Medical Scheme. These complementary products are not medical scheme benefits. You may be a member of Momentum Medical Scheme without taking any of the complementary products.
- If you choose to continue with any of these products, please complete this form.

1: Complementary products

Please indicate which complementary products should be transferred | AdviceFee ☐ | HealthSaver ☐ | Multiply ☐

Effective date of transfer | 0 | 1 | M | M | Y | Y | Y | Y |

2: Transfer of HealthSaver

2.1 Transfer of HealthSaver due to principal member swop

Complete this section if the HealthSaver is being transferred from the current principal member to the new principal member.

- Does the new principal member require the credit option for HealthSaver? Yes ☐ No ☐
  (If yes, please complete the *Application for complementary products*)
- Does the new principal member accept liability for negative balance owing on the current HealthSaver? Yes ☐ No ☐
  (If no, please complete the *Application for complementary products*)

2.1.1 Positive or negative balances in the current HealthSaver

Should the current balance in the HealthSaver be paid out to the previous principal member? Yes ☐ No ☐

(If yes, please complete the banking details)

Name of account holder

Name of bank

Account number

Account type | Current/Cheque ☐ | Savings ☐ | Transmission ☐

Branch code | Branch name

Should the balance remain in the HealthSaver as part of the change of principal member? Yes ☐ No ☐

Signature of current principal member **Date** D D M M Y Y Y Y

Signature of new principal member **Date** D D M M Y Y Y Y

2.2: Transfer of HealthSaver due to the death of the principal member

2.2.1 Negative HealthSaver balances

- Please provide the date when the balance will be settled by the Estate D D M M Y Y Y Y
- If no Executor of Estate is appointed, does the new principal member accept liability for negative balances owed on the current HealthSaver? Yes ☐ No ☐
  (If no, a new HealthSaver contract number will be issued for the new principal member.)

2: Transfer of HealthSaver (continued)

2.2: Transfer of HealthSaver due to the death of the principal member (continued)

2.2.2 Positive HealthSaver balances to be paid to the Estate

The HealthSaver account will be reinstated with the change of principal member. The balance at the time of reinstatement will be available for use, unless indicated that this needs to be paid to the Executor of the Estate.

Should the current available balance be paid out to the Executor of the Estate? Yes ☐ No ☐

If the HealthSaver balance needs to be paid to the Executor of the Estate, the HealthSaver account will remain terminated. Please attach the proof of the Estate's banking details.

Signature of new principal member _____ **Date** D D M M Y Y Y Y

3: Banking details for payment of contributions

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

Contribution payer	**Multiply**	**HealthSaver***	**AdviceFee**
Principal Member	☐	☐	☐
Company (as per company application form)	☐	☐	☐

* If you are changing banking details for HealthSaver contributions, please also complete the FICA verification details in section 3.

(Please do not provide credit card details. Momentum 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

Amount: HealthSaver R _____ AdviceFee R _____ Multiply R _____

Start date: 0 1 M M Y Y Y Y

Please note that the complementary product(s) will only be activated upon successful activation of your Momentum Medical Scheme membership.

Notes:

- The deduction date is the first working day of the month.
- The abbreviated name as registered with the bank, which will reflect on your bank statement, is:
  - HealthSaver: Health Sav followed by your membership number
  - AdviceFee: Advice Fee followed by your membership number
  - Multiply: Momentum followed by your membership number

4: FICA verification for HealthSaver

In terms of the Financial Intelligence Centre Act (FICA), we need to successfully perform FICA verification before we activate the HealthSaver account.

If a third party pays your HealthSaver contribution, FICA is required for the third party as well.

We therefore require the following information:

- Source of funds for payment of contributions
  - Income (salary, commission and rentals) ☐
  - Dividends interest and dividend income ☐
  - Pension or provident fund, retirement annuity and annuity ☐
  - Other (Please provide details) ☐
- ID/Passport number for the principal member
  - If passport number, please confirm which country the passport was issued in and provide a copy of the passport.
- ID/Passport number for the contribution payer if different to principal member
  - If passport number, please confirm which country the passport was issued in and provide a copy of the passport.
- Company name and registration number if a company is the contribution payer (only required where a company application form has not been completed and submitted).
  - Company name
  - Company registration number
- If the contribution is paid by a trust by virtue of a testamentary disposition, by virtue of a court order, in respect of persons under curatorship, or by the trustees of a retirement fund in respect of benefits payable to the beneficiaries of that retirement fund, we require:
  - a copy of the trust deed for local trusts, or
  - a letter of authority or other official document from a competent trust registering authority in the foreign jurisdiction for foreign trusts.

4: FICA verification for HealthSaver (continued)

For all other trusts we require the name and ID/Passport number for each trustee:

Name of trustee	ID/Passport number	If passport number, please confirm which country the passport was issued in and provide a copy of the passport.

5: 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. I accept that failure to pay the amount, due and payable within 30 days from the due date, will lead to termination. I may cancel this mandate and pay via other methods within the 30 days. If I cancel this mandate, I remain responsible to pay any amounts due to Momentum while it was in force.

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.

*Consent from third party:

I (name and surname)

ID number

consent to Momentum deducting the contributions due for this member from my bank account.

Signature of principal member or third party (if applicable)

Date D D M M Y Y Y Y

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

Date D D M M Y Y Y Y

Company stamp

6: Terms and conditions

For protection of personal information

Momentum Metropolitan Holdings Limited comprises a group of companies that provide the following products and services:

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

Momentum Metropolitan Holdings Limited and its subsidiaries will keep your personal information confidential and will adhere to the Protection of Personal Information Act 4 of 2013 when processing your personal information. We request your consent to process your personal information and to obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement to enable Momentum Metropolitan Holdings Limited and its subsidiaries to offer you the products set out above and to administer the products.

1. I declare that all my personal information and that of my dependants supplied to Momentum Metropolitan Holdings Limited and its subsidiaries is accurate, up to date, not misleading and that it is complete in all respects and will be held and/or stored securely for the purpose for which it was collected and that I will immediately advise Momentum Metropolitan Holdings Limited or its subsidiaries of any changes to my personal information and that of my dependants should any of these details change.
2. I confirm that I am authorised to provide consent in this section on behalf of my dependants, and that I have their permission to share such information with Momentum Metropolitan Holdings Limited and its subsidiaries. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and I have the authority to give consent for them.

6: Terms and conditions (continued)

For protection of personal information (continued)

3. I hereby authorise, and give consent to Momentum Metropolitan Holdings Limited and its subsidiaries to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of Momentum Metropolitan Holdings and its subsidiaries), with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity. This personal information will be processed and/or used for further processing in order to administer the products or services.
4. I understand that the personal information will be shared to provide for the following purposes:
   - To interact with, and view all the products and services I have with Momentum Metropolitan Holdings Limited on its websites including obtaining a single view of my products within Momentum Metropolitan Holdings Limited.
   - For the administration, underwriting, credit scoring, client reporting and risk profile analysis of products and services where I and/or my dependants have a contractual relationship in relation to such products or services or where I and/or my dependants have applied for such products or services.
   - To provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
   - For any other lawful purpose.
5. I acknowledge that my dependants and I must give Momentum Metropolitan Holdings Limited and its subsidiaries, as applicable, all information and evidence that may be required from time to time. I authorise Momentum Metropolitan Holdings Limited and its subsidiaries to obtain from any person, including the medical schemes to which my dependants and I belong and/or its administrator, any information Momentum Metropolitan Holdings Limited and its subsidiaries may require concerning me or any of my dependants in relation to the products or services I and/or my dependants currently have or have applied for. I consent to that person providing, and instruct that person to provide, Momentum Metropolitan Holdings Limited and its subsidiaries with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
6. I understand that I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
7. I understand that I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
8. I understand that if I fail to provide the personal information required or if I am not willing to agree to the processing of my personal information, then Momentum Metropolitan Holdings Limited and its subsidiaries will not be able to offer me the products or to administer them. My personal information will be processed in terms of the following statutes, amongst others the Medical Schemes Act 131 of 1998, the Financial Intelligence Centre Act 38 of 2001, the Financial Advisory and Intermediary Act 37 of 2002, the Long-Term Insurance Act 52 of 1998, the Insurance Act 18 of 2017, the National Credit Act 34 of 2005 and the Pension Funds Act 24 of 1956.
9. I understand that I have the right to request my personal information which is under the control of Momentum Metropolitan Holdings Limited and its subsidiaries provided that I furnish adequate identity and that a fee may be charged for this service.
10. I understand that I have the right to request Momentum Metropolitan Holdings Limited and its subsidiaries where necessary, to correct, or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
11. If I have a complaint relating to the processing of my personal information, I understand that I should first refer it to Momentum Metropolitan Holdings Limited to resolve it in terms of their internal complaints process. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 010 023 5207 or via email at POPIAComplaints@inforegulator.org.za.
12. You can access Momentum Metropolitan Holding's full privacy policy at https://www.momentummetropolitan.co.za/en/policy/privacy-notice and Momentum Multiply's full policy at https://www.multiply.co.za/engaged/privacy-policy.

Signature of principal member **Date** D D M M Y Y Y Y

For Multiply

1. I, the main member, hereby apply for my dependants and I to join Momentum Multiply (the programme), which is administered by Momentum Multiply (Pty) Ltd (Multiply) and agree that I and my dependants will be bound by the terms and conditions and rules thereof.
2. Multiply reserves the right to amend its rules and benefits unilaterally. A copy of the terms and conditions and rules can be obtained from https://www.multiply.co.za/engaged/terms-and-conditions or from the Multiply client contact centre on 0861 88 66 00.
3. I undertake to obtain the necessary consents from any of my dependants to whom these terms and conditions and rules may apply and hereby indemnify Multiply against any claim which may arise as a result of my failure to do so.
4. I consent to the recording of all conversations between me and Multiply and all information obtained through these conversations will form part of Multiply's records. I also consent to all these records remaining the sole property of Multiply.
5. I acknowledge that Multiply reserves the right to cancel the membership applied for in this application if I or any of my dependants breach any of the terms and conditions or rules of the programme which are subject to change from time to time.
6. I understand that I will receive mandatory communication from Multiply as a legal requirement of my membership and that I am able to review and update my communication preferences by visiting the terms and conditions on the Multiply website.
7. I understand that I may contact the Multiply call centre on 0861 88 66 should I wish to cancel my membership.
8. If I have a complaint related to the product or services received, I understand that I should first refer the complaint to Multiply by calling 0861 88 66 00 or emailing multiply@momentum.co.za to resolve the complaint according to the internal complaints processes. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the National Consumer Commission by calling 012 428 7000 or emailing complaints@thencc.org.za.
9. I declare that the answers that I have provided in this application are true and complete. I understand that if my dependants and I are accepted as members of the programme, my answers on this application will form the basis of the membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by any other third party on my behalf.

6: Terms and conditions (continued)

For HealthSaver

1. I am deemed to have read and understood the Terms and Conditions that apply to HealthSaver, which can be accessed via the website at momentum.co.za, and consider myself bound by these Terms and Conditions. I further agree to refer to the Momentum website (momentum.co.za) annually to take note of the terms and conditions.
2. An annual administration fee of R40 is payable in January of each year.
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 Terms 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.
   iv. I undertake to submit the information required for FICA purposes within 14 (fourteen) days of my application. Failure to submit the FICA information will result in my application for the HealthSaver account being cancelled.

   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.

For AdviceFee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Medical Scheme.
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 Medical Scheme
   - keeping Momentum Medical Scheme informed of changes in my membership details
   - informing me of changes in my contributions to Momentum Medical Scheme, and
   - advising me of changes to the product and benefits that Momentum Medical Scheme offers.
3. This fee may be reviewed annually when my contributions to Momentum Medical Scheme are reviewed and increased by a rate based on the average contribution increase to Momentum Medical Scheme. I will receive reasonable written notice of any such intended change.
4. The agreement will start when I become a member of Momentum Medical Scheme, unless stated otherwise, and will end when my financial adviser is not entitled to receive compensation for my membership of Momentum Medical Scheme for any reason whatsoever.
5. I acknowledge that this fee will not form part of my contribution to Momentum Medical Scheme and will therefore be a separate charge.
6. I instruct Momentum Metropolitan Life Limited 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.

Sign here to accept the terms and conditions relevant to the complementary products you are applying for.

Signed at

Signature of principal member

Date D D M M Y Y Y Y

GapCover

Take care of medical practitioner shortfalls and co-payments for in-hospital procedures through Momentum GapCover. Momentum GapCover is underwritten by Guardrisk Insurance Company Limited, a wholly owned subsidiary of Momentum Metropolitan Holdings Limited. To apply, please speak to your financial adviser.