momentum
medical scheme

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

Application for addition of dependants

2024

Important notes:

- Momentum Medical Scheme is a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Momentum Medical Scheme is administered by a separate company, Momentum Health Solutions (Pty) Ltd (Administrator), part of Momentum Metropolitan Holdings Limited.
- Please do not resign your dependants from their current medical scheme until you have received written notification of acceptance from Momentum Medical Scheme.
- Momentum Medical Scheme will only consider membership on receipt of a fully completed application form.
- Please provide the ID/passport number and copy of ID/passport for all additional dependants.
- Please ensure that the first name and surname of all additional dependants are completed in accordance with their ID or passport.
- 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 your dependants.
- Please provide certificates of membership for previous schemes, where applicable.
- It is very important to disclose full information in the medical details sections regarding any pre-existing condition or symptoms experienced by your dependants. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.
- Please email the completed and signed form to us at **healthnewbusiness@momentumhealth.co.za**.
- Please note that Momentum Medical Scheme's 2024 benefits and contributions amendments, including registration of the new Fusion Option, have been submitted to the Council for Medical Schemes (CMS). The 2024 benefit and contributions amendments await approval by the Registrar and are therefore subject to such approval. The Scheme is in discussion with CMS regarding registration of the new Fusion Option and awaits a final decision from the Registrar.

1: Personal details of principal member

Membership number

First name

Surname

Cellphone number

Email address

Correspondence to be sent to ☐ Member ☐ Financial Adviser ☐ Employer group contact

2: Personal details of additional dependants

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

Race ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

☐ I would prefer not to disclose my race

We collect race information for statistical purposes for the Council for Medical Schemes.

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: Personal details of additional dependants (continued)

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

Race: African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

I would prefer not to disclose my race ☐

We collect race information for statistical purposes for the Council for Medical Schemes.

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

Race: African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

I would prefer not to disclose my race ☐

We collect race information for statistical purposes for the Council for Medical Schemes.

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 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

Race: African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

I would prefer not to disclose my race ☐

We collect race information for statistical purposes for the Council for Medical Schemes.

2: Personal details (continued)

2.2 Dependants (continued)

Dependant 3 (continued)

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

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

I would prefer not to disclose my race ☐

We collect race information for statistical purposes for the Council for Medical Schemes.

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: Previous medical scheme information

List each medical scheme that your dependants have been a member of (note that only medical schemes registered in South Africa apply). This information needs to be supplied for all dependants applying for membership. If more space is required, please include additional pages.

Please provide certificates of membership for previous schemes.

Name of dependant	Name of scheme	Membership number	Date joined yy/mm/dd	Date terminated yy/mm/dd or current

Are the details completed above the same for all dependants applying for cover? Yes ☐ No ☐

If no, please provide details in the space above.

Have your dependants been forced to change their medical scheme due to no longer being eligible to remain on their current scheme? Yes ☐ No ☐

If yes, please include a certificate of membership from their current scheme, along with proof of the forced move (such as copy of resignation letter).

4: Medical details

Please make sure that you have completed Section 3 before completing this section.

Doctor/s consulted in the past 12 months

If your dependants applying for membership have consulted a doctor in the past 12 months, please list all doctors that were consulted.

Name and surname			
Telephone - work		How long has he/she been your doctor (years)?	
Name and surname			
Telephone - work		How long has he/she been your doctor (years)?	
Name and surname			
Telephone - work		How long has he/she been your doctor (years)?	

Dependants living with HIV/Aids

If your dependants are living with HIV/Aids and you would prefer not to disclose this for confidentiality purposes, please contact LifeSense on 0860 50 60 80 within 14 days of receiving confirmation that they have been added to your membership, to disclose your dependants' condition. We may apply a 12-month condition specific waiting period for this condition or a 3-month general waiting period. If we do, we will inform you. If you do not contact LifeSense within 14 working days, we may terminate your Momentum Medical Scheme membership, as this may be considered non-disclosure of information. This information will be kept confidential.

☐ Tick here to indicate that you have read the disclaimer, and that the same information has been shared with all your dependants included on the application form.

4.1

Complete this section if your dependants have been a member of a medical scheme registered in South Africa for at least 24-months and less than 90 days have passed since their resignation from that scheme. If not, please complete Section 4.2.

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from their treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

In the last 12 months, have your dependants had any of the following:

4.1.1	Are your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months?	Yes ☐	No ☐
4.1.2	Have your dependants had an operation or admission to any hospital in the last 12 months?	Yes ☐	No ☐
4.1.3	Are your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months?	Yes ☐	No ☐
4.1.4	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by your dependants, or that could potentially result in a medical claim within the next 12 months?	Yes ☐	No ☐

All questions must be answered with a 'Yes or 'No'. If 'Yes' to any question, please provide full details below. If more space is required please include additional pages.

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2

Complete Section 4.2 if:

- your dependants have not been a member of a medical scheme registered in South Africa for more than 90 days; or
- your dependants have been a member of a medical scheme registered in South Africa for less than 24-months and less than 90 days have passed since their resignation from that scheme.

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from their treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

All questions must be answered with a 'Yes' or 'No'. If 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

In the last 12 months, have your dependants had any of the following:

4.2.1	**Disorders or problems with the heart or cardiovascular system.** E.g. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack?	Yes ☐	No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4: Medical details (continued)

4.2 (continued)

4.2.2 **Respiratory or lung trouble.** E.g. COVID-19, tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, upper respiratory tract infection, sinusitis or allergic rhinitis? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver.** E.g. constipation, reflux, abdominal pains, gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure, or have you ever had a gastroscopy, colonoscopy, or other special examinations? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs.** E.g. urinary tract infections, abnormal urine tests, kidney stones, nephritis, prostatitis, abnormal prostate-specific antigen (PSA), bladder infections, or sexually transmitted disease? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.5 **Disorders of the nervous system or brain.** E.g. seizures, epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have any of your dependants had or been advised to have a specialised scan, e.g. MRI, CT or PET scan? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.6 **Mental disorders.** E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, stress, post-traumatic stress disorder, drug abuse or alcohol abuse? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.7 **Ear, nose, throat or eye disorders.** E.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, earache, ear infection (otitis media), tonsillitis, adenoiditis or allergies? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs or spine.** E.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint pain/problems or replacements, multiple sclerosis, acne, eczema or psoriasis? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.9 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.10 **Cancer,** a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant. Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4: Medical details (continued)

4.2 (continued)

4.2.11 Are any of your dependants currently undergoing, or anticipating any specialised dental/maxillo facial treatment? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.12 Are any of your dependants taking ongoing medication for any condition not listed in any other question? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.13 Have any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.14 Are any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.15 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by your dependants, or that could potentially result in a medical claim within the next 12 months? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

Questions 4.2.16 to 4.2.17 apply to female applicants

4.2.16 Have any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, excessive/abnormal bleeding, pelvic pains, endometriosis, ovarian cysts, Polycystic ovarian syndrome (PCOS), fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do any of your dependants suspect that they may be pregnant? Yes ☐ No ☐

Name of dependant	Condition and date diagnosed	Name of medication	Currently on treatment?	Last treatment/ symptoms date	Attending doctor

4.2.17 Are any of your dependants currently pregnant? Yes ☐ No ☐

5: Consent for Momentum Medical Scheme to process personal information

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 authorise, and give consent to Momentum Medical Scheme and the Administrator to collect, store, collate, process, share and further process the personal information, including health information of my dependants, for purposes of their Momentum Medical Scheme membership risk profiling and management, administration of their membership and as set out herein.
3. My dependants personal information, where applicable, will be shared between Momentum Medical Scheme, the Administrator, any subsidiaries within Momentum Metropolitan Holdings Limited with whom my dependants have any financial or insurance products, including complementary products and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes of:
   - Administering products and services related to their membership of Momentum Medical Scheme;
   - granting only adult dependants access to interact with Momentum Medical Scheme on its website;
   - obtaining a single view of their products with Momentum Metropolitan Holdings Limited;
   - receiving any reports or statements including consolidated reporting and
   - For any other lawful purpose.

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

4. I (insert name and surname) _____

   hereby give consent to Momentum Medical Scheme's Administrator, for my dependants 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 my dependants by means of electronic communication. Tick here if your dependants do not wish to receive any direct marketing. ☐

5. 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

6: Terms and conditions

1. I apply for my dependants 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 to add my dependants to my 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. 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 dependants' 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 my dependants in order for the application to be assessed.
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 dependants' health 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 any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 4, on pg 3).
12. I will notify the Scheme should 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 are accepted as members of the Scheme, the 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.**

6: Terms and conditions (continued)

Should Momentum Medical Scheme confirm your dependants' start date or terms of acceptance before activation?* Yes ☐ No ☐

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

Signed at

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

You may not backdate the start date. Your membership may only start on the first day of next month, or on the first day of the month thereafter.

* 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

7: Employer warrantee for payment of contributions

To be signed by an employer representative if the company pays your contribution.

- Momentum Medical Scheme may bill us for the increased contributions 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

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: _____ and membership number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax (VAT).

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Membership number: _____ ID or passport number: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____

Benefits of appointing

Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:

Guide:
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

Educate:
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

Protect:
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
  - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

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