momentum
medical scheme

Option Selection Form

2022

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 19 November 2021.** The requested changes will be effective from 1 January 2022.

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 601+
- R10 251 - R14 600
- R7 751 - R10 250
- R776 - R7 750
- ≤ R775

*If less than R14 601, 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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