momentum
medical scheme

Option selection form

2027

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 30 November 2026.** The requested changes will be effective from 1 January 2027.
- Momentum Medical Scheme's 2027 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

≤ R1 600 | R1 601 - R9 800 | R9 801 - R13 100 | R13 101 - R18 850

R18 851 - R24 500 | R24 501+

*If less than R24 501, 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