momentum
health

2012 Option Selection Form

- **If your employer pays your contributions, employer approval is compulsory. Please submit this form, fully completed, to your HR or Payroll department.**
- If you are an individual member, please fax this form, fully completed, to the Momentum Health membership department on **0860 77 55 66.**
- This form must reach Momentum Health by 30 November 2011, requested changes are effective form 1 January 2012.

Member number

Employee number

You only need to complete this form if you want to change your current option and/or choice of provider(s). Please ensure that all the selections for your chosen option are completed. Incomplete information will cause a delay in the processing of your Option Selection Form.

Personal details - Principal member

Title

Initials

Surname

ID number

Cellphone number

E-mail

Ingwe Option

Out-of-hospital provider
- CareCross
- Prime Cure

In-hospital provider
- Ingwe Network
- State

Salary
- More than R8 400
- R6 301 - R8 400*
- R3 951 - R6 300*
- Less than R3 950*

*Please attach a copy of your payslip.

Out-of-hospital provider's practice number

Out-of-hospital provider's practice name

Access Option

Out-of-hospital provider
- CareCross
- Medicross
- Prime Cure

In-hospital provider
- Access Network

Out-of-hospital provider's practice number

Out-of-hospital provider's practice name

Custom Option

Out-of-hospital provider
- Any
- State
- Associated GP and Courier Pharmacies

In-hospital provider
- Any hospital
- Associated hospitals

Incentive Option

Out-of-hospital provider
- Any
- State
- Associated GP and Courier Pharmacies

In-hospital provider
- Any hospital
- Associated hospitals

Savings: 10%

Extender Option

Out-of-hospital provider
- Any
- State
- Associated GP and Courier Pharmacies

In-hospital provider
- Any hospital
- Associated hospitals

Savings: 25%

Pay day-to-day claims
- At Accumulation rate of 100% of Momentum Health Rate
- Up to 200% of the Momentum Health Rate

Summit Option

Out-of-hospital provider
- Freedom-of-choice

In-hospital provider
- Any hospital

Declaration

I confirm that I understand the benefits offered under the benefit option I have selected and agree to be bound by the Rules applicable thereto.
I agree to pay the relevant contribution according to the benefit option and providers I have selected.

Signature of Principal Member

Date D D - M M - 2 0 Y Y

Employer Approval

Name and surname of authorised person

Designation

Signature of authorised signatory

Employer stamp

Date D D - M M - 2 0 Y Y