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momentum health

Option Selection Form

2019

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 Health membership department via email at **mhmembership@momentum.co.za** or fax to **0860 77 55 66**.
- Please make sure that this form reaches Momentum Health by **no later than 23 November 2018.** The requested changes will be effective from 1 January 2019.

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

- R12 501 +
- R9 001 - R12 500
- R6 801 - R9 000
- R701 - R6 800
- ≤ R700

*If less than R12 501, please complete the **Declaration of Income**

GP's practice number

GP's name

Impact Option

Hospital provider	Chronic provider	Day-to-day provider
Impact Network	Impact Primary Care Network	Impact Primary Care Network Provider

GP's practice number

GP's name

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 Health 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 – 2 0 Y Y

Employer approval (to be completed if your employer pays your contributions)

Name

Designation

Signature of authorised person

Date D D – M M – 2 0 Y Y

Employer stamp

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