momentum
health

Continuation form

2008

Complete this form in the following scenario
- In the event of you retiring from your employer;
- In the event that your employment with your employer is terminated due to ill-health or other disability

Please provide a copy of ID, for all beneficiaries

Please note that all your existing membership details, including beneficiaries, will be retained. Should there be any changes, please notify us in writing and attach with this form.

Section 1: Personal details

Principal member

Membership number

Title | Initials | First name

Surname

Previous surname

ID/Passport number*
*If passport number, please supply date of birth
Y Y M M D D | Gender: Male | Female

Country of residence | Marital status

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

E-mail address

Monthly Income

Section 2: Banking details for payment of contributions

(Momentum Health does not debit from credit card accounts)

Name of account holder

Name of institution

Account number

Account type | Current | Savings | Transmission | Deduction day 0 1

Branch code | Branch name

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. I / we agree to inform Momentum Health in writing of any changes that take place. I / we authorise Momentum Health to verify such account details with the financial institution. We accept that Momentum Health may debit the account on a date other than specified.

Signature of account holder/ Authorised signatory

Date D D – M M – 2 0 Y Y

Section 3: Banking details for claim refunds payable to member

Name of account holder

Name of institution

Account number

Account type | Current | Savings | Transmission

Branch code | Branch name

Signature of principal member

Date D D – M M – 2 0 Y Y

Section 4: Financial adviser

Do you want to continue with your current financial advisor? Yes ☐ No ☐

Name	Financial adviser's code	Broker house code	Commission ref no.	Commission split %
				100 %

I declare that the applicant has appointed me as their broker and the applicant is entitled to cancel my services at any time.

Signature of financial adviser **Date** D D – M M – 2 0 Y Y

Section 5: Terms and conditions

1. I apply for my dependants and me to join Momentum Health (the Scheme) administered by Momentum Medical Scheme Administrators (MMSA) (the Administrator) and agree to familiarise myself with, and be bound by, the Rules of the Scheme (the Rules) if my application for 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 am aware that the Scheme may ask for proof of identification at any stage.
3. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contribution.
   - Non-receipt of a single month's contribution will result in suspension of medical scheme benefits. This suspension will last until I have paid all contributions in arrears.
   - Non-receipt of two months' contributions will result in cancellation of my membership of the Scheme.
4. 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.
5. I will pay all sums that I owe to the Scheme on demand.
6. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Scheme, my answers on this form will form the basis of my membership.
7. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme and that the Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that has existed on my admission date.
8. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, I authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.
9. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme against any claim which may arise as a result of my failure to do so.
10. I will notify the Scheme if I or any of my dependants are living with HIV/Aids.
11. I understand that if I have selected the Base or Access Options, day-to-day and chronic claims will be paid only for the chosen providers.
12. Words used in this application have the meaning that the Rules give them.
13. 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.
14. I acknowledge that my 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.

Signed at

Name

Signature of principal member **Date** D D – M M – 2 0 Y Y