

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	
ID number		Surname	
Email		Cellphone number	

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
		R18 851 - R24 500	R24 501+
			R9 801 - R13 100
			R13 101 - R18 850

*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
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Custom Option	☐	Hospital provider	Chronic provider
		Any hospital	Any
		Associated hospitals	State
			Associated GP and Courier Pharmacies

Incentive Option	☐	Hospital provider	Chronic provider	Savings: 10%
		Any hospital	Any	
		Associated hospitals	State	
			Associated GP and Courier Pharmacies	

Extender Option	☐	Hospital provider	Chronic provider	Savings: 25%
		Any hospital	Any	
		Associated hospitals	State	
			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	☐
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Summit Option	☐	Hospital provider Any	Chronic and Day-to-day provider Freedom-of-choice
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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
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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			