

Option Selection Form

2025

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 29 November 2024**. The requested changes will be effective from 1 January 2025.
- Momentum Medical Scheme's 2025 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	<input type="text"/>	Employee number	<input type="text"/>
Title	<input type="text"/> Initial/s <input type="text"/> Surname	<input type="text"/>	
ID number	<input type="text"/>	Cellphone number	<input type="text"/>
Email	<input type="text"/>		

Option choice

<input type="checkbox"/> 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	R22 401+	R17 001 - R22 400	R11 951 - R17 000	R9 001 - R11 950
	R1 501 - R9 000	≤ R1500		
	*If less than R22 401, please complete the Declaration of Income			
GP's practice number	<input type="text"/>			
GP's name	<input type="text"/>			

<input type="checkbox"/> Evolve Option	Hospital provider Evolve Network	Chronic provider State
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<input type="checkbox"/> Custom Option	Hospital provider	Chronic provider	
	Any hospital	Any	State
	Associated hospitals	Associated GP and Courier Pharmacies	

<input type="checkbox"/> Incentive Option	Hospital provider	Chronic provider	Savings: 10%
	Any hospital	Any	State
	Associated hospitals	Associated GP and Courier Pharmacies	

<input type="checkbox"/> Extender Option	Hospital provider	Chronic provider	Savings: 25%
	Any hospital	Any	State
	Associated hospitals	Associated GP and Courier Pharmacies	

How would you like us to pay your day-to-day claims?

<input type="text"/>	<input type="text"/>
At the claims accumulation rate	At up to 200% of the Momentum Medical Scheme Rate

<input type="checkbox"/> 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	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Employer approval (to be completed if your employer pays your contributions)

Name

Designation

Signature of authorised person	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer stamp	<input type="text"/>								