momentum
medical scheme

Option Selection Form

2024

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 2023.** The requested changes will be effective from 1 January 2024.
- Please note that Momentum Medical Scheme's 2024 benefits and contributions amendments, including the new Fusion Option, have been submitted to the Council for Medical Schemes, and the Scheme awaits approval by the Registrar. Therefore, the proposed changes are subject to such approval by the Registrar.

Member details

Member number | Employee number

Title | Initial/s | Surname

ID number | Cellphone number

Email

Option choice

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 Network provider ☐

Income: R16 101+ ☐ | R11 326 - R16 100 ☐ | R8 551 - R11 325 ☐ | R876 - R8 550 ☐ | ≤ R875 ☐

*If less than R16 101, please complete the **Declaration of Income**

GP's practice number

GP's name

Fusion Option ☐ — **Hospital provider** Fusion Network — **Chronic provider** State

Income: R22 201+ ☐ | R16 101 - R22 200 ☐ | R11 326 - R16 100 ☐ | R8 551 - R11 325 ☐ | ≤ R8 550 ☐

*If less than R22 201, please complete the **Declaration of Income**

Evolve Option ☐ — **Hospital provider** Evolve Network — **Chronic provider** State

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 Medical Scheme 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 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

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