

## Option selection form

2026

### 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](mailto:mhmembership@momentum.co.za).
- Please make sure that this form reaches Momentum Medical Scheme by **no later than 28 November 2025**. The requested changes will be effective from 1 January 2026.
- Momentum Medical Scheme's 2026 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"/> <b>Ingwe Option</b>	<b>Hospital provider</b>	<b>Chronic and Day-to-day provider</b>		
	Connect hospitals	State facilities		
	Ingwe Network hospitals	Ingwe Primary Care Network provider		
	Any hospital	Ingwe Active Network provider		
<b>Income</b>	R23 501+	R18 001 - R23 500	R12 501 - R18 000	R9 401 - R12 500
	R1 551 - R9 400	≤ R1 550		
	*If less than R23 501, please complete the <b>Declaration of Income</b>			
GP's practice number	<input type="text"/>			
GP's name	<input type="text"/>			

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

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

<input type="checkbox"/> <b>Extender Option</b>	<b>Hospital provider</b>	<b>Chronic provider</b>	<b>Savings: 25%</b>
	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"/> <b>Summit Option</b>	<b>Hospital provider</b> Any	<b>Chronic and Day-to-day provider</b> 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.

<b>Signature of principal member</b>	<input type="text"/>	<b>Date</b>	<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

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