Thank you for choosing the **Momentum Ingwe Local Student Plan.**
Herewith, the application. Please complete:

SECTION 1 – YOUR DETAILS

SECTION 2 – PREVIOUS MEDICAL AID INFORMATION (IF ANY)

SECTION 3 – YOUR MEDICAL INFORMATION.

SECTION 3.1 – COMPLETE IF YOU HAVE BEEN ON A MEDICAL AID FOR AT LEAST 2-YEARS AND LESS THAN 3-MONTHS SINCE YOU LEFT IT.

OTHERWISE COMPLETE 3.2
ANY YES ANSWER, PLEASE GIVE FULL INFORMATION.

SECTION 4 – IF YOU EARN AN INCOME, PLEASE INSERT IT HERE

SECTION 5 – DEBIT BANK ACCOUNT DETAILS **–** THIS CAN BE ANYONE. - **SIGN**

SECTION 6 – BANK DETAILS FOR CLAIM REFUNDS **– SIGN**

SECTION 7 – SIGN CONSENT

SECTION 8 – SIGN AND DATE

Kind regards,

PETER

Peter J Pyburn
Approved Financial Services Provider Licence # 2995.

Financial Life Planner
Member: Masthead, FIA, Accredited with Council for Medical Schemes.
☎ **Mobile: 083 377 8893**
Fax: **0866 688 122**

PS. Please visit my Web page - **www.peterpyburn.co.za**

"My interest is in the future, as I'm going to spend the rest of my life there." C. Kettering

momentum
health

Application for membership - Local student

2018

Important notes:

- Momentum Health is a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Momentum Health is administered by a separate company, MMI Health (Pty) Ltd (Administrator), a division of MMI Group Limited.
- Please do not resign from your current medical scheme until you have received written notification of acceptance from Momentum Health.
- Momentum Health will only consider membership on receipt of a fully completed application form.
- Please provide the ID number and copy of ID for the principal member and all dependants, where applicable.
- If a third party will be a paying your contribution, please provide a copy of their ID.
- Please attach proof of full time studies at registered academic institution.
- Please provide certificates of membership for previous schemes, where applicable.
- It is very important to disclose full information in the medical details sections regarding any pre-existing condition or symptoms experienced by you or your dependants. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.
- Please submit the completed and signed form via email to **studenthealth@momentum.co.za.**
- Should we not receive all the required supporting documents, it will delay the finalisation of your application.

Section 1: Personal details

Principal member

Name of institution where studying

Campus | Student number

Identity number | Date of birth D D – M M – Y Y Y Y

Title | Initials | First name

Surname

Gender Male ◯ Female ◯ | Marital status

Telephone - home | Cellphone number

Email address

Postal address

Postal code

Residential address

Postal code

Please note that the email address you provide will be used when the Scheme communicates with you.

Spouse or partner (If spouse or partner is also applying for membership)

Title | Initials | First name

Surname

Previous surname | Gender Male ◯ Female ◯

ID/Passport number | Date of birth D D – M M – Y Y Y Y

Country in which passport was issued

Country of residence

Telephone - home | Cellphone number

Email address

Section 1: Personal details (continued)

Dependants (If dependants are also applying for membership)

Dependant 1

First name

Surname

ID/Passport number | Gender Male ○ Female ○

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ○ No ○ | Dependant's monthly income R

Dependant 2

First name

Surname

ID/Passport number | Gender Male ○ Female ○

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ○ No ○ | Dependant's monthly income R

Dependant 3

First name

Surname

ID/Passport number | Gender Male ○ Female ○

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ○ No ○ | Dependant's monthly income R

Dependant 4

First name

Surname

ID/Passport number | Gender Male ○ Female ○

Country in which passport was issued

Date of birth (D D – M M – Y Y Y Y) | Cellphone number

Email address

Relationship to principal member

Is the dependant financially dependent on principal member? Yes ○ No ○ | Dependant's monthly income R

Section 2: Previous medical scheme information

List each medical scheme that you have been a member of (note that only medical schemes registered in South Africa apply). This information needs to be supplied for the principal member and all dependants applying for membership. If more space is required, please include additional pages.

Please provide certificates of membership for previous schemes.

Name of member	Name of scheme	Membership number	Date joined yy/mm/dd	Date terminated yy/mm/dd or current

Are the details completed above the same for all dependants applying for cover? Yes ○ No ○

If no, please provide details in the space above.

Have you been forced to change your medical scheme due to no longer being eligible to remain on your current scheme? Yes ○ No ○

If yes, please include a certificate of membership from your current scheme, along with proof of the forced move (such as copy of resignation letter).

Section 3: Medical details

Please make sure that you have completed Section 2 before completing this section.

Principal member

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Spouse or partner

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 1

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 2

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 3

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Dependant 4

Height , m Tobacco smoked Quantity per day

Mass kg Alcohol consumed Quantity per week Type

Doctor/s consulted in the past 12 months

If your family has consulted more than one doctor in the past 12 months, please list all doctors that you consulted.

Name and surname

Telephone - work How long has he/she been your doctor (years)?

Name and surname

Telephone - work How long has he/she been your doctor (years)?

Name and surname

Telephone - work How long has he/she been your doctor (years)?

Section 3: Medical details (continued)

If you or any of your dependants are living with HIV/Aids.

If you would prefer not to disclose the nature of the HIV-status on this form due to confidentiality, you may wait until you have received your valid Momentum Health membership number. On receipt of your membership number, you have 14 working days to contact LifeSense Disease Management on 0860 50 60 80 in order to notify us that you or your dependants are living with HIV/Aids, failing which your membership may be terminated for nondisclosure. This information will be kept confidential.

☐ Tick here to indicate that you have read the disclaimer, and that the same information has been shared with all your dependants included on the application form.

Section 3.1

Complete this section if you have been a member of a medical scheme registered in South Africa for at least 24-months and less than 90 days have passed since your resignation from that scheme. If not, please complete Section 3.2.

It is very important to disclose full information regarding any pre-existing medical condition or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

In the last 12 months, have you or your dependants had any of the following:

3.1.1 Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months? Yes ○ No ○

3.1.2 Have you or your dependants had an operation or admission to any hospital in the last 12 months? Yes ○ No ○

3.1.3 Are you or your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months? Yes ○ No ○

3.1.4 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months? Yes ○ No ○

3.1.5 Is there any other condition, which is not detailed in any questions above, for which medical advice, diagnosis, care or treatment has already been recommended to, or received by, you or any of your dependants? Yes ○ No ○

All questions must be answered with a 'Yes or 'No'. If you have answered 'Yes' to any question, please provide full details below. If more space is required please include additional pages.

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 3.2

Complete Section 3.2 if:

- you have not been a member of a medical scheme registered in South Africa for more than 90 days; or
- you have been a member of a medical scheme registered in South Africa for less than 24-months and less than 90 days have passed since your resignation from that scheme.

It is very important to disclose full information regarding any pre-existing medical condition or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

All questions must be answered with a 'Yes' or 'No'. If you have answered 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

In the last 12 months, have you or your dependants ever had any of the following:

3.2.1 **Disorders or problems with the heart or cardiovascular system.** E.g. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.2 **Respiratory or lung trouble.** E.g. tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 3: Medical details (continued)

Section 3.2 (continued)

3.2.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver.** E.g. gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis,cirrhosis, liver failure, or have you ever had a gastroscopy, colonoscopy, or other special examinations? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.4 **Disease or disorders of the kidneys, bladder or reproductive organs.** E.g. abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections, or sexually transmitted disease? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.5 **Disorders of the nervous system or brain.** E.g. epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's diseae, or have you or any of your dependants had or been advised to have an MRI or CT scan? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.6 **Mental disorders.** E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, post-traumatic stress disorder or substance abuse? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.7 **Ear, nose, throat or eye disorders.** E.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs or spine.** E.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint trouble, multiple sclerosis, any joint problems or replacements, acne, eczema or psoriasis? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.9 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.10 **Cancer,** a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant. Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.11 Are you or any of your dependants currently undergoing, or anticipating any specialised dental/maxillo facial treatment? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Section 3: Medical details (continued)

Section 3.2 (continued)

3.2.12 Are you or any of your dependants taking ongoing medication for any condition not listed in any other question? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.13 Have you or any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.14 Are you or any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.15 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.16 Is there any other condition or symptom, which is not detailed in any other question, that you or any of your dependants have experienced and for which you have not yet sought medical advice? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Questions 3.2.17 to 3.2.18 apply to female applicants

3.2.17 Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant? Yes ○ No ○

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

3.2.18 Are you or any of your dependants currently pregnant? Yes ○ No ○

Section 4: Option

Ingwe Option **Chronic and Day-to-day provider:** Ingwe Active Primary Care Network **Hospital provider:** Any hospital

Gross monthly income R

Please provide us with the following documents as proof of income (please note that the documents are required for you and your spouse or partner if he/she is included on your membership):

- If employed, your latest payslip or IRP5 certificate. If you earn a variable income please provide us with your last 3 months' payslips.
- If self-employed, copies of the latest current audited financial statements of your company and the last 3 months' bank statements for you and your company.
- If unemployed, your last 3 months' statements of all your bank accounts, as well as an affidavit confirming that you are unemployed and that these are your only bank accounts.

Section 5: Banking details for payment of contributions

(Please do not provide credit card details. Momentum Health is not allowed to record your credit card details.)

Name of account holder

Name of bank

Account number

Account type Current/Cheque ◯ Savings ◯ Transmission ◯

Branch code - - - Branch name

Section 6: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

Momentum Health may debit the above account with the amount due under the contract in accordance with the Momentum Health debit order system. Momentum Health will debit the bank account for contributions on the 1st working day of every month. I understand that Momentum Health bills for contributions in advance and dependent on my commencement and activation dates there may be more than a single contribution payable to the Scheme.

If an **individual's** account is to be debited:

If a third party's account details are used, please provide a copy of their ID.

X **Signature of account holder** **Date** D D – M M – 2 0 Y Y

If a **company** account is to be debited:

- Momentum Health may bill us for the amount due for this member in the same manner as for other members that our organisation employs.

Name

Position in company

Signature of account holder/ Authorised signatory **Date** D D – M M – 2 0 Y Y

Company stamp

Section 7: Banking details for claim refunds payable to member

You, as the principal member, need to sign this section if a third party's bank details are being used for claims reimbursement. If a third party's account details are used, please provide a copy of their ID.

☐ Tick this box if we may use the same bank account details provided for your Momentum Health contribution payments.

If not, please complete the bank details below.

(Please do not provide credit card details. Momentum Health is not allowed to record your credit card details)

Name of account holder

Name of bank

Account number

Account type Current/Cheque ◯ Savings ◯ Transmission ◯

Branch code - - - Branch name

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

Section 8: Consent for Momentum Health to process personal information

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Momentum Health.

Momentum Health and the Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Momentum Health will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to Momentum Health and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Momentum Health membership risk profiling and management, administration of my membership and as set out in this section.
2. If I have consented to the disclosure of my personal information, Momentum Health or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Momentum Health or the Administrator which requires them to do so.
3. I acknowledge that I must give Momentum Health and the Administrator all information and evidence they may require from time to time. I authorise Momentum Health and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Momentum Health may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of Momentum Health and risk profiling or management. I consent to that person providing, and instruct that person to provide, Momentum Health and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
6. I have the right to request my personal information which is in the possession of Momentum Health and the Administrator, provided that I furnish adequate identification.
7. I have the right to request Momentum Health and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
9. My personal information will be shared between Momentum Health, the Administrator and contracted third parties both locally and outside the Republic of South Africa who requires this information, for purposes related to my membership of Momentum Health and to grant me access to interact with Momentum Health on its website.
    - to grant me access to interact with Momentum Health on its website; and
    - to provide any credit bureau or registered credit provider with your credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).
10. I agree that Momentum Health's Administrator, MMI Health, a division of MMI Group Limited, may use my information for the purpose of marketing (including direct marketing) of insurance, investments, health insurance, retirement benefits, other financial services and health related products offered by MMI and its subsidiaries. Tick here if you do not wish to receive any direct marketing. ☐

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

Section 9: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by MMI Health (Pty) Ltd (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 acknowledge that if my dependants and I do not disclose all the information that is relevant to the assessment of this application or if I and my dependants submit fraudulent claims, it will make any contracts to which this application relates null and void. The Scheme may, at its discretion, retain all contributions or recover any amounts paid to me or any service provider on my behalf.
3. I will notify the Scheme of any changes that take place, in any circumstances on which the Scheme based its assessment of its risk (including my health status), after the date of this application form and prior to my joining date. I acknowledge that failure to do so will result in the termination of my contract with the Scheme. In such event, the Scheme will have the right to reclaim any amounts that it may have paid to me or any person on my, or my dependants' behalf, under such contract.
4. I understand that this application form is valid for 30 days only from the date of signature.
5. I am aware that this application must be accompanied by proof of identification for me and my dependants in order for the application to be assessed.
6. It is my responsibility alone (as a member) to make sure that the Scheme receives the monthly contributions as well as any other amounts I owe to the Scheme.
    - Non-receipt of contributions will result in suspension of medical scheme benefits for my entire contract. This suspension will last until I have paid all outstanding contributions.
        - I understand that whilst my contract is suspended, the Scheme will not honour any claims related to services rendered for the period that the membership is suspended.
        - I understand that I will remain fully liable to pay contributions for the period of suspension.

Section 9: Terms and conditions (continued)

- Non-payment of more than one month's contribution will result in termination of my membership of the Scheme.
- Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection.

7. 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.
8. I will pay all sums that I owe to the Scheme on demand. Failure to pay any debt due to the Scheme will result in suspension and eventually termination of membership and handover to a third party for debt collection. Refer to point 6.
9. 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 existed for a period of up to twelve (12) months prior to my application to join the Scheme.
10. I acknowledge that the Scheme has the right to apply a three-month general waiting period, a twelve-month exclusion on a pre-existing condition, and/or Late-joiner contribution penalty, where applicable.
11. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership (See section 3, on page 4).
12. I will notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.
13. I undertake to give a calendar month's notice should I wish to terminate my membership.
14. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and / or Administrator against any claim which may arise as a result of my failure to do so.
15. Words used in this application have the meaning that the Rules give them.
16. 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.
17. I acknowledge that my duly appointed 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.
18. I understand that I need to provide full and complete information, even if I have already done so for other policies held with any of the subsidiaries of MMI Group Holdings Limited, as Momentum Health and MMI Holdings are separate entities.
19. **The answers that I have provided in this application are full, complete and true. I understand that if my dependants and I are accepted as members of the Scheme, my answers on this application will form the basis of our membership. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser, or any other third party on my behalf.**

Should Momentum Health confirm your start date or terms of acceptance before activation?* Yes ◉ No ○

* Where waiting periods and/or Late Joiner Penalties apply to your membership, you will be required to sign an acceptance letter before Momentum Health activates your membership.

Signed at

Starting date* 0 1 – M M – 2 0 Y Y

* Remember to inform us should any information provided on this form change between the date of signing the form and the starting date.

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

For office use

Broker code 5 6 0 6 2 4 Broker house code 0 2 4 2 0 5

Group code Institution code