momentum
health

Super group application for membership

Includes Multiply, HealthSaver, AdviceFee and HealthWaiver **2014**

Important notes:

- 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 a copy of ID for principal member, spouse and adult dependants.
- Please ensure that the first name and surname of the principal member, spouse and dependants are completed in accordance with the ID or passport.
- If your employer is not already registered as a group on Momentum Health, a company application form needs to be completed.
- Please submit the completed and signed form via fax to 031 580 0430 or email at healthnewbusiness@momentumhealth.co.za.

Section 1: Personal details

Principal member

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

Marital status | Single | Married | Separated | Divorced | Widowed

Home address

Postal code

Postal address (if different)

Postal code

Telephone - home | Cellphone number

Email address

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

Would you like to receive marketing information from Momentum Health? | Yes | No

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: Employer information

Company Name

Branch name | Branch number

Existing group number | Employee number

Business telephone number | Date of employment D D – M M – Y Y Y Y

Principal member's monthly income

Principal member's occupation

Section 3: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %
				100 %

Signature of financial adviser

Date D D – M M – **2 0** Y Y

How would you like to receive the welcome pack? Mail to member ☐ Send to branch ☐

Section 4: Marketing adviser (where applicable)

Name and surname

Marketing adviser's code | Branch name

Telephone – work | Cellphone number

Email address

Section 5: Option choice

Important note: The option you choose may only be changed with effect from 1 January of each year, by submitting an option change form to Momentum Health before 30 November of the previous year.

HealthSaver: The Momentum HealthSaver is a free product, which you can add to your option. You can use this account as you see fit to make provision for additional healthcare expenses. We need your consent to activate your HealthSaver (see page 6).

Ingwe Option ☐

Hospital provider	Chronic and Day-to-day provider	Income
State hospitals	Ingwe Primary Care Network provider ☐	More than R9 400 ☐
Ingwe Network	Ingwe Primary Care Network provider ☐	R6 951 – R9 400* ☐
Any hospital	Ingwe Active Primary Care Network provider ☐	R5 201 – R6 950* ☐
		R501 – R5 200* ☐
		Less than R500* ☐

Provider's practice number

Provider's practice name

* If less than R9 400, please complete the Declaration of Income

Access Option ☐

Hospital provider
Access Network

Chronic and Day-to-day provider
Access Primary Care Network

Provider's practice number

Provider's practice name

Custom Option ☐

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

Incentive Option ☐

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

Section 5: Option choice (continued)

Extender Option	Hospital provider	Chronic provider	Savings: 25%
	Any hospital	Any	
	Associated hospitals	Associated GP and Courier Pharmacies	
		State	
Pay day-to-day claims at:	Accumulation rate	Up to 200% of the Momentum Health Rate	

Summit Option	Hospital provider	Chronic and Day-to-day provider
	Any hospital	Freedom-of-choice

Section 6: Employer warranty for payment of contributions

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- 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

(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

Signature of principal member

Date D D – M M – 2 0 Y Y

Section 8: Terms and conditions

1. I apply for my dependants and I to join Momentum Health (the Scheme) administered by Momentum Medical Scheme Administrators (Pty) Ltd (MMSA) (the 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, 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.

Section 8: Terms and conditions (continued)

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 during this period.
     – I understand that I will remain fully liable to pay contributions for the period of suspension.
   - Non-payment of more than one month's contribution will result in cancellation 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 may result in suspension of membership and/or handover to a third party for debt collection. Refer to point 6.
9. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Scheme, my answers on this form will form the basis of my membership.
10. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, I authorise the Scheme and/or the Administrator and/or my financial adviser to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other healthcare provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.
11. In the case of new members of the Scheme, the Scheme has the right to apply the following:
    - A three-month general waiting period;
    - A twelve-month exclusion on a pre-existing condition; and/or
    - Late-joiner contribution penalty.
12. I will notify the Scheme if I or any of my dependants are living with HIV/Aids within 14 days of activation of membership.
13. 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.
14. I undertake to give 30 days notice should I wish to terminate my membership.
15. 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.
16. Words used in this application have the meaning that the Rules give them.
17. 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.
18. 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.
19. 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.

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

Signature of principal member

Date D D – M M – **2 0** Y Y

momentum

Annexure for complementary products

2014

Important notes:

- Momentum Health members may add any of these complementary products.
- You need to complete the contract details for each product required.
- We will use the personal details completed for Momentum Health for this contract.

Product Selection:

Please indicate which complementary products you are applying for, complete the relevant sections and sign page 11.

Multiply		**HealthSaver**		**AdviceFee**		**HealthWaiver**	

Section 1: Multiply contract details

Contributions will be calculated based on the membership composition of Momentum Health:

- Single member
- Family of two
- Family of three or more

How would you like to receive your welcome pack?

Mail		Client collect		Branch		Broker collect	

Section 2: HealthSaver contract details

Section 2.1: Free HealthSaver account

☐ Tick this box if you would like Momentum to activate your free HealthSaver account.

You can use this account as you see fit to make provision for additional healthcare expenses

If you do **not** wish to start contributing to HealthSaver at this point, complete Section 2.1 and Section 7.

Section 2.2: HealthReturns

☐ Tick this box if you want your HealthReturns to be paid into your HealthSaver account.

(And be eligible for HealthReturns Booster. If you do not select this option, HealthReturns will be paid into the same account that Momentum Health uses to refund your claims).

Section 2.3: Monthly HealthSaver

☐ Tick this box if you want to start contributing to your HealthSaver and complete your chosen amount below:

Monthly amount R | | | | | | | Minimum of R100 per month

You can choose to contribute any amount in addition to the regular monthly payments. These additional amounts can be paid via Electronic Fund Transfer (EFT).

Section 2.4: Apply for credit

☐ Tick this box if you want to apply for credit on the above monthly amount and complete the information below.

Credit assessment inventory (complete if you are applying for credit on your monthly contributions)

Joint gross monthly household income subtotal	R
Joint monthly household expenses	
a) Discretionary expenses (e.g. movies, eating out)	R
b) Contractual expenses (e.g. car repayments, retail accounts)	R
Expenses subtotal	R
Net monthly income	**R**

Section 2: HealthSaver contract details (continued)

Credit provider information

In terms of the regulations of the National Credit Act 34 of 2005, the following information must be supplied.

NCR number	NCR CP 173
Name of credit provider	MMI Group Limited
Physical Address	268 West Avenue Centurion Gauteng 0157
Contact number	0860 11 78 59 Weekdays 08:00 to 17:00

Section 3: AdviceFee contract details

Please select one of the following AdviceFee options:

Standard monthly amount ☐ R 35.00 ☐ R 63.00 ☐ R 84.00 ☐ R 100.00 Increase option ☐ Annual Increase

Section 4: HealthWaiver

Section 4.1 Insured life/lives

Insured life/lives ☐ Principal member ☐ Spouse

Section 4.2 Contract details

Benefit payment term ☐ 5 years ☐ 10 years

Have you smoked or used any other form of tobacco in the past twelve months?

Principal member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Medical disclaimer

Have you suffered from or do you currently suffer from or take any chronic treatment for any disease, for example cancer, cardiovascular, kidney disease, stroke, HIV/Aids, respiratory, neurological or connective tissue disease?

Principal member ☐ Yes ☐ No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		☐ Yes	☐ No	Y Y M M	☐ Yes	☐ No
		☐ Yes	☐ No	Y Y M M	☐ Yes	☐ No

Spouse ☐ Yes ☐ No

If yes,

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		☐ Yes	☐ No	Y Y M M	☐ Yes	☐ No
		☐ Yes	☐ No	Y Y M M	☐ Yes	☐ No

Exclusion for pre-existing condition

All claims arising from any physical defects, illnesses, bodily injuries or diseases that the insured life suffered from, was aware of, or has received medical treatment or advice for in the three years prior to the starting date of a qualifying benefit, are excluded for the first three years from the starting or restarting date of that benefit. If no such qualifying benefit exists, the 3-year period will apply to the starting date of this benefit. If the principal member upgrades his options under his Momentum Health membership or adds new dependants (except as a result of marriage or child birth) to his Momentum Health membership, a new 3-year period will apply to the increase in the Momentum Health contribution from the date of the increase.

Please read the clause below carefully. It contains provisions that potentially compromise your rights.

1. Any physical defect, illness, bodily injury or disease that I or my dependants suffered from, were aware of or received treatment for in the past three years is considered a pre-existing condition.
2. I understand that any claim due to a pre-existing condition will not be covered for the first three years from the starting or re-starting of a qualifying benefit.
3. If no such qualifying benefit exists, the three year period will apply to the starting date of this benefit.
4. If I, as the principal member, upgrade my options under my Momentum Health Membership or add new dependants (except as a result of marriage, childbirth or adoption) to my Momentum Health Membership, a new three year period will apply to the increase in my Momentum Health contribution from the date of the upgrade.

I have read and understand the above clause, have had an opportunity to question and consider it and I agree to the consequences of it.

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

Signature of spouse _____ **Date** D D – M M – 2 0 Y Y

Section 4: HealthWaiver (continued)

Section 4.3 Start of policy

The starting date will depend on the starting date of your Momentum Health membership. This policy cannot have a starting date that is earlier than the Momentum Health starting date.

Section 4.4 Replacement of insurance

Do any benefits under this policy replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance that you discontinued within the past four months or that you will discontinue within the next four months)? Yes ☐ No ☐

If Yes, the financial adviser must discuss the facts and implications with the applicant, then fill in the Replacement Policy Advice Record and attach it to this application form. Replacement of any insurance is generally to the disadvantage of the applicant because it involves duplication of the initial costs charged to the policy.

Section 4.5 Policy Holder details

Name of legal entity			
Contact person in case of legal entity			
Registration number		Registration date	D D – M M – Y Y Y Y
Postal address			
		Postal code	
Telephone - work		Fax number	
Cellphone number			
Email address			
Preferred method of communication	Email ☐	Post ☐	
Tax status	Company / Close Corporation (M) ☐	Natural persons (N) ☐	Non-taxable institution (I) ☐
Tax status of trust beneficiaries if the applicant is a trust company	Company (C) ☐	Natural persons (P) ☐	Non-taxable institution (Z) ☐

Section 5: Contribution payer information

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

Please indicate the contribution payer for each of the complementary products applied for:

Contribution payer	Multiply	HealthSaver	AdviceFee	HealthWaiver
Principal Member (complete only section 5.2)	☐	☐	☐	☐
Company (as per company application form – ignore sections 5.1 and 5.2)	☐	☐	☐	☐
Other (complete sections 5.1 and 5.2)	☐	☐	☐	☐

Section 5.1

Title	Initials	First name	
Surname			
ID/Passport number		Gender	Male ☐ Female ☐
RSA ID	Yes ☐ No ☐	Date of Birth	D D – M M – Y Y Y Y
Home address			
		Postal code	
Postal address (if different)			
		Postal code	
Telephone - home		Cellphone number	
Email address			

Section 5: Contribution payer information (continued)

Section 5.2

(Please do not provide credit card details. Momentum 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

I authorise Momentum to debit the account as supplied on this application form with the amount of the contribution that I have agreed to pay per complementary product. I undertake to inform Momentum of any change in the account details. I authorise Momentum to verify such account details with my financial institution. I accept that Momentum may debit the account on a date other than specified.

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

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

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

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- Momentum 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

Section 7: Terms and conditions

For Multiply

1. I, the principal member, hereby apply for my dependants (where applicable) and me to become members of Multiply, which is administered by Momentum Interactive (Pty) Ltd. If Momentum Interactive (Pty) Ltd accepts this application then this application will serve as evidence that I agree to be bound by the rules of Multiply and undertake to adhere to such rules at all times. I may obtain a copy of the rules from the Momentum website (www.momentum.co.za) or the Multiply client contact centre at 0861 88 66 00.
2. I consent to paying the monthly contributions in return for the benefits supplied by Multiply to my dependants (where applicable) and myself. I understand that it is my sole responsibility to ensure that my monthly contributions are received by Momentum Interactive (Pty) Ltd.
3. I acknowledge that Momentum Interactive (Pty) Ltd reserves and shall have the right to cancel the membership applied for herein if I or any of my dependants (that are members of the programme by virtue of this application) breach any of the terms and conditions of this agreement inclusive of rules and regulations pertaining to the Multiply programme in force from time to time.
4. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally from time to time, but shall inform members of any such amendments. I understand that I may cancel my participation on Multiply at any time, including when I do not accept the amended rules and benefits.

For HealthSaver

1. I agree to be bound by the Rules and Conditions that apply to the HealthSaver and the terms and conditions of the loan agreement as set down in the Rules and Conditions.
2. I have been provided with a copy of the Rules and Conditions and I have been given an opportunity to consider, familiarise myself with and agree to the Rules and Conditions.
3. I appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the HealthSaver and for making the relevant payments as per the Rules and Conditions.
4. I acknowledge that:
   i. In doing so, Momentum acts as my agent.
   ii. I assume all risks connected with the administration of the entrusted funds by Momentum, understanding that Momentum is bound by the Financial Institutions (Protection of Funds) Act 28 of 2001.
   iii. I will direct all enquiries in respect of the HealthSaver to Momentum.

   I have read and understand the above clause, have had an opportunity to question and consider it and I agree to the consequences of it.

Section 7: Terms and conditions (continued)

Credit granting for application

1. I confirm that the above information is true and complete.
2. I understand that the information provided under the Credit Assessment Inventory will yield a net income figure and that this will determine whether credit will be granted.
3. I understand that the maximum credit I can qualify for is R19 200.
4. I agree that ad-hoc contributions and rebates will not affect the credit advanced to me.
5. I agree that my application is subject to verification, processing and screening and that Momentum may decline an application based on these checks. In addition I give consent that upon acceptance my application will still be subject to continuous screening which may lead to the termination of my application or a reduction in the amount advanced to me when necessary.
6. Momentum reserves the right to share my payment behaviour with various credit bureaus and I understand that this will have an impact on my credit worthiness.
7. I give Momentum the right to, upon the cancellation or termination of the HealthSaver product, offset any debt owing by me to Momentum Health or any Momentum product from funds available in the HealthSaver;
8. I give Momentum the right to, upon the cancellation or termination of the HealthSaver product, hand over my unpaid accounts in respect of the HealthSaver for collection and listing on the credit bureaus.
9. I understand that credit granted will be subject to a variable interest rate.

For AdviceFee

1. I acknowledge that my financial adviser has agreed to render certain services to me arising from my membership of Momentum Health.
2. The services that my financial adviser has agreed to render to me include, but are not limited to:
    - handling enquiries in relation to my membership of Momentum Health
    - keeping Momentum Health informed of changes in my membership details
    - informing me of changes in my contributions to Momentum Health, and
    - advising me of changes to the product and benefits that Momentum Health offers.
3. This fee may be reviewed annually when my contributions to Momentum Health are reviewed and increased by a rate based on the average contribution increase to Momentum Health. I will receive reasonable written notice of any such intended change.
4. The agreement will start when I become a member of Momentum Health, unless stated otherwise, and will end when my financial adviser is not entitled to receive compensation for my membership of Momentum Health for any reason whatsoever.
5. I acknowledge that this fee will not form part of my contribution to Momentum Health and will therefore be a separate charge.
6. I instruct MMI Group Ltd to collect the above fee, on the due date, in terms of the payment details given in this application and pay my financial adviser on my behalf.

For HealthWaiver

I accept and understand that I am limiting my right to privacy. However, to enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits under this or any other application for insurance that I have made or that was made for me as the insured life, I authorise the MMI Group Limited, a registered long-term insurer, including the current and future subsidiaries and/or representatives (Momentum):

- to obtain from any person, including Momentum Health and their administrators, any information that Momentum needs in connection with this application or the policy. I also authorise and instruct such person to give the said information to Momentum, and
- to share with other insurers that information and any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

1. This document and any documents that were submitted in connection with it form the basis of the contract I intend entering into, and all information that I have supplied is correct and complete.
2. I undertake to let Momentum know in writing if a change takes place in the health of the insured life/lives between the date of this application and the starting date of the policy or the acceptance date, whichever occurs last.
3. Only the conditions in the contract will bind Momentum and not the representations or undertakings that any person makes or gives.
4. I consent that Momentum may inform anyone who later owns this policy if Momentum adjusts the benefits or the premium under this policy for any reason.
5. I understand that Momentum will cancel the insurance contract that it has issued under this application if the insured life/lives has/have withheld any material information on this application form, or answered any question/s incorrectly, and that the policyholder will forfeit all premiums that he/she paid.
6. I understand that I may cancel this contract within 30 days of the date of the letter of acceptance. I also understand that if I use this right, Momentum will pay back all premiums that I have paid, after Momentum has deducted the cost of any benefits I have enjoyed, the cost of any investment and/or currency risk exposure, and certain expenses.

Section 7: Terms and conditions (continued)

For HealthWaiver (continued)

7. I acknowledge that I have read the valid and official quotation that Momentum has issued that sets out the policy benefits for which I have applied in the properly completed policy application. I confirm that my authorised financial adviser has explained the contents of the quotation to me and I agree that the details set out in it will bind me.
8. I acknowledge and understand that the MMI Group Limited and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain if I sign this application before completing it in full. I acknowledge and understand that it is an offence to sign a blank or incomplete application form, as stated in the Policyholder Protection Rules that have been published under the Longterm Insurance Act 52 of 1998.
9. I am aware that any information provided for the purpose of this application is subject to the stipulations of the Financial Intelligence Centre Act 38 of 2001 and that it will be dealt with in accordance with requirements that the Act contains.
10. I acknowledge that I have read the declaration above, that I fully understand the nature and effect of it and that it will bind me.
11. I accept all legal risks associated with communicating with Momentum via the electronic medium that I chose in this communication, and I indemnify and hold Momentum harmless against any consequent loss that I or any third party may suffer as a result of the misuse, misapplication, or misinterpretation of this communication. In the event of a conflict between the contents of this communication and any subsequent written instruction of the policyholder, this communication will take precedence, and will be binding on the policyholder, provided that this communication has been properly completed and is regular on the face of the document.

Signed at

Signature of principal member

Date D D – M M – **2 0** Y Y