

Option selection form

2027

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 2026**. The requested changes will be effective from 1 January 2027.
- Momentum Medical Scheme's 2027 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"/>
ID number	<input type="text"/>	Surname	<input type="text"/>
Email	<input type="text"/>	Cellphone number	<input type="text"/>

Option choice

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		≤ R1 600	R1 601 - R9 800
		R18 851 - R24 500	R24 501+
		R9 801 - R13 100	R13 101 - R18 850

*If less than R24 501, please complete the Declaration of Income

GP's practice number	<input type="text"/>
GP's name	<input type="text"/>

Evolve Option	☐	Hospital provider Evolve Network	Chronic provider State
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Custom Option	☐	Hospital provider	Chronic provider
		Any hospital	Any
		Associated hospitals	State
			Associated GP and Courier Pharmacies

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

Extender Option	☐	Hospital provider	Chronic provider	Savings: 25%
		Any hospital	Any	
		Associated hospitals	State	
			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	☐
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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	<div></div>	Date	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>
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Employer approval (to be completed if your employer pays your contributions)

Name	<div></div>		
Designation	<div></div>		
Signature of authorised person	<div></div>	Date	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>
Employer stamp	<div></div>		