Checked and verified by your employer	
Employer's signature	

For Momentum Health Solutions use only		
Membership number		
Ref	Date	Type

CHANGE IN MEMBER/DEPENDANT STATUS

MEMBER'S DETAILS

Membership number | Company

Name | Employee number

Surname

Email address

Cell phone number 0

Residential address

Code

IMPORTANT POINTS

- Complete all sections
- Complete the medical history for yourself and your dependants
- Sign and date the form
- Return this form to your manager
- Affidavits are available from your HR representative.

Please tick the appropriate box. CHOOSE ONE OF THE FOLLOWING and COMPLETE THE RELEVANT SECTION BELOW.

1. ADD ☐ **2. DELETE** ☐ **3. RETIREMENT** ☐ **4. MARRIAGE** ☐ **5. DEATH OF MEMBER** ☐

1. ADD Please provide membership certificates of previous medical schemes as well as marriage and/or birth certificates, where applicable.

Dependant	Initials	First name	Surname	ID number or date of birth	Relationship	Gender	Adult/Child
1							
2							
3							

Reason for addition: Married ☐ Newborn ☐ Change in employment ☐ Closure of medical scheme ☐ Other ☐

Please provide the name of the additional dependant's previous medical scheme (Please attach a certificate of membership).

Name of previous medical scheme | Duration of cover Years + Months

Add dependants with effect from D D M M Y Y Y Y

Please note:

Any dependant over 21 will **not** be admitted for membership, unless they are:

- your spouse
- your common-law partner
- your child who is financially dependent on you for family care and support, because he/she is:
  - unemployed
  - unmarried
  - mentally or physically disabled
  - not a beneficiary of another registered medical scheme.

Continued overleaf

1. ADD (CONTINUED) Please provide membership certificates of previous medical schemes as well as marriage and/or birth certificates, where applicable.

For spouse/partner/dependants that are 18 years and older, please complete the contact information fields (cell phone number, email address and residential address).

Spouse/Partner

First names

Surname Gender Male ☐ Female ☐

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

Relationship to applicant (e.g. wife)

Cell phone number 0

Email address

Residential address

Code

Additional dependant

First names

Surname Gender Male ☐ Female ☐

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

Relationship to applicant (e.g. wife)

Cell phone number 0

Email address

Residential address

Code

2. DELETE Delete with effect from D D M M Y Y Y Y Member ☐ Dependant ☐

Dependant	Initials	First name	Surname	ID number or date of birth	Reason for deletion
1					
2					
3					

3. RETIREMENT Date of retirement D D M M Y Y Y Y Employee number

Address

4. MARRIAGE **Change of name for female member now married.**

New surname

Date of marriage D D M M Y Y Y Y **(PLEASE PROVIDE COPY OF MARRIAGE CERTIFICATE).**

5. DEATH OF MEMBER **A membership application form for continued membership must be completed by widow/er/orphan should he/she wish to remain on the Fund. (PLEASE PROVIDE COPY OF DEATH CERTIFICATE.)**

Name of deceased

Date of death D D M M Y Y Y Y Membership number

TERMS AND CONDITIONS

A. GENERAL

Membership of the Wooltru Healthcare Fund (Healthcare) is a compulsory condition of employment unless you belong to your spouse's medical fund. New employees have 30 days from the date they become eligible within which to apply for membership of Healthcare for themselves and their dependants, failing which, the waiting periods will apply.

B. DEPENDANTS

In terms of the Fund's rules, the following persons may be included as your dependants, provided that they are not a member or a registered dependant of any other medical scheme:

1. Your spouse:
Please note that your marriage must be legally recognised by South African law or customary law.

2. Your common-law partner:
A common-law partner is a person with whom the member has a committed and serious relationship akin to a marriage based on mutual dependency and a shared and common household, irrespective of the gender of either party. You will need to provide the Fund with an affidavit to this effect.

3. Your children:
- Your natural child (under the age of 21) who is dependent on you.
- Your stepchild (under the age of 21) who is dependent on you.
- A child (under the age of 21) who has been placed in your or your spouse's legal custody and who is dependent on you.
  You will need to provide the Fund with the legal papers.
- Your legally adopted child (under the age of 21) who is dependent on you. You will need to provide the Fund with the adoption documents.
- A child who is 21 years or older and who is dependent on you due to mental or physical disability. You will need to provide the Fund with the applicable medical records.

4. Additional adult:
- An unemployed child who is 21 years or older and dependant on you for financial care and support. You will need to provide the Fund with an affidavit to this effect.
- Please note that you pay child rates for children under the age of 21 and adult rates for children over the age of 21, unless they are mentally or physically disabled.

5. The parents of the principal (main) member only:
You may register your mother and father, if they are legally dependent on you for financial care and support and earn less than the maximum of a social pension per month. You will need to provide the Fund with an affidavit to this effect.

6. Your ex-spouse:
Your ex-spouse may be registered as an additional adult dependent under the following circumstances:
- There must be a legal obligation on you in terms of the divorce settlement to provide your ex-spouse with medical scheme benefits, and your ex-spouse must remain unmarried.
- Upon the death of the principal member, rule 6.3.6 refers.

C. FREQUENTLY ASKED QUESTIONS

1. Where can I obtain the relevant affidavits mentioned?
The relevant affidavits may be obtained from your HR representative or printed from Imbizo.

2. When do my benefits start? Your benefits start on your first day of employment unless waiting periods have been imposed.

3. How are my contributions collected?
Your contributions are deducted from your salary/pension each month and paid to the Fund.

4. What should I do if I need another membership card? Contact the Fund's Client Services Call Centre on 080 222 8922 or 021 480 4849 and request another card.

5. What must I do when my personal circumstances change? You must notify the Fund within 30 days of any change in your membership status, for example if:
- you get married
- you get divorced
- one of your dependants dies
- your address or contact details change
- your children no longer qualify for dependent membership in terms of the Fund rules
- you go on pension.

IMPORTANT: You need to notify the Fund within 90 days of the birth of your child or the adoption of a child.

WAITING PERIODS

A. WAITING PERIOD DEFINITIONS

The categories of members or employees covered in the waiting period schedule are:
- current employee
- child dependant
- spouse
- additional adult
- parents of the member and
- current pensioner.

Please bear in mind that benefits start from your date of employment unless a waiting period has been applied.

B. WHEN WAITING PERIODS ARE APPLIED

New employee: No waiting periods are imposed on new employees or their dependants, as long as they are registered within 30 days of joining the company.

Adding a newborn, adopted or fostered child: No waiting periods are imposed on a newborn child or an adopted child provided they are registered within 90 days of becoming eligible.

Adding a spouse/common-law partner: No waiting periods are imposed on a spouse or common-law partner, as long as they are registered within 30 days of becoming eligible.

All other additions to membership other than the above: A three-month waiting period is imposed at all times. However, additional waiting periods will be imposed if the dependant:
- was not a member of another medical scheme in the three months before applying to join Healthcare;
- was a member of a medical scheme for less than two years before applying to join Healthcare.

C. WAITING PERIODS

The following waiting periods are allowed in terms of the Act:

1. Three-month general waiting period: You contribute towards the Fund but may not claim for any services during the three-month period. Only emergency hospitalisation will be covered, unless you were without cover for 90 days or more
prior to joining the Fund.

2. Nine-month waiting period on existing pregnancies: A condition-specific waiting period of up to nine months may be applied on existing pregnancies in respect of all pregnancy-related services.

3. Twelve-month, condition-specific exclusion: A pre-existing illness is a condition or illness where medical advice, diagnosis, care or treatment was recommended or received within the 12 months prior to applying for membership of the Fund. Treatment, medication and surgery for this condition or illness may be excluded for 12 months from the date of joining the Fund. However, emergency admissions for certain pre-existing conditions **may** still be covered. In the event that you were without cover (not on a registered medical scheme) for **90 days or more prior** to joining the Fund, you will not be covered for the pre-existing condition(s), including emergencies, during the 12-month period.

CONTRIBUTIONS

GENERAL

The number of dependants you register with the Fund determines your contributions. Your contributions are payable monthly in advance, on or before the first day of each month.
- If you join on or before the 15th of a month, your first contribution will be calculated from the start of that month.
- If you join after the 15th of a month, your first contribution will be payable from the first day of the following month.

Your contributions will be deducted from your salary/pension and paid to the Fund.

PRE-EXISTING MEDICAL CONDITIONS

The Fund reserves the right to impose waiting periods as defined in the rules. Should any of these apply to you, you will be notified in writing by the Fund within one month of registration. Please supply full details on the enclosed Medical History of Employee and Dependants form if you or any of your dependants have had one or more pre-existing medical condition/s during the last 12 months. (Exclude minor ailments.)

CONSENT TO DISCLOSE INFORMATION

Wooltru Healthcare Fund (the Fund) and its contracted service providers undertake to keep your personal information and the personal information of your dependants confidential. In return you agree to the Fund and/or its service providers processing and disclosing your personal information as follows:

1. The collection, collation, processing, storing and disclosure of your and all your dependants' personal information **for the following purposes ONLY:**
- for the administration of your Fund benefits;
- for the provision of the Fund's managed care services to you and your dependant/s;
- for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you or any of your dependant/s on behalf of the Fund; and
- for trend or risk analysis, peer review or participation in clinical studies, in which case your information will be provided on an anonymous basis.

2. The Fund and/or its service providers will only share your personal information or the information of any of your dependants if it is requested by a third party to whom you have already given your consent for the disclosure of such information.

3. If we are required to share your information for any other reason, **we will only do so with your written permission.**

4. When providing the Fund and/or its service providers with personal information about your dependants, you confirm that you have, where applicable, received appropriate permission to disclose such information.

MEDICAL HISTORY OF ADDITIONAL DEPENDANTS

Please complete details in the columns provided in respect of your dependants (including new infants).
Answer all questions/Complete all blocks.

	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
DEPENDANT'S NAME				
1. Are any of your dependants undergoing medical treatment for any conditions currently or in the past 12 months?				
2. Will any of the above require an operation in the near future?				
3. Please indicate if these persons are currently pregnant and, if so, the expected date of delivery.				
4. Details of any chronic illness. Please provide names of medicines.				
Allergies				
Arthritis, limb or back problems				
Asthma or any other respiratory disorder				
Blood disorders				
Cancers				
Dermatitis or other skin disorder				
Diabetes, thyroid disease				
Fits/epilepsy				
Heart conditions				
High blood pressure				
HIV/AIDS and other immunity problems				
Kidney and urological disease				
Menopause				
Nervous or mood disorders				
Raised cholesterol				
Stomach or abdominal complaints				
Other (details)				

I, the undersigned, hereby make application to be admitted as a member of the Wooltru Healthcare Fund (Healthcare) and, if admitted, agree to abide by the constitution and rules of Healthcare. I certify that the above information is true and correct to the best of my knowledge and belief, and declare that any false statement in this application will render my membership null and void. I further agree to the following;

(a) THAT ANY AMOUNTS DUE BY ME TO THE HEALTHCARE FUND MAY BE DEDUCTED FROM MY SALARY;
(b) THAT, IN THE EVENT OF MY WITHDRAWAL FROM THE HEALTHCARE FUND, ANY AMOUNTS DUE BY ME TO THE FUND, MAY BE DEDUCTED FROM ANY MONIES DUE TO ME FROM THE COMPANY;
(c) That, if any amount due by me cannot be deducted as per (a) or (b) above, I undertake to pay such amount directly to the Healthcare Fund;
(d) That should I or any of my dependants, require hospitalisation, I agree to provide access to the information required by the Healthcare Fund.

I acknowledge that medical information will be reviewed by clinical staff employed by Healthcare's appointed Administrator to assist in managing members and dependants cost-effectively. I am also aware that medication and expensive procedures will be subject to clinical review and that benefits are based on formularies and protocols.

Signature of member _____ **Date** _____