Checked and verified by your employer	
Employer's signature	

For Momentum Health use only		
Membership number		
Ref	Date	Type

MEMBERSHIP RECORD AMENDMENT

MEMBER'S DETAILS (COMPULSORY TO COMPLETE)

Membership number | Employer name

Name | Employee number

Surname

Physical address

Code

Email address

Cell phone number 0

Race* African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes

IMPORTANT POINTS

- Complete all sections to prevent a delay in the processing of the application.
- Complete the medical history section.
- Sign and date the form.
- Return this form to your manager.
- Affidavits are available from your human resources (HR) representative.

1. CHANGES IN MEMBERSHIP DETAILS

CHOOSE ONE OF THE FOLLOWING and COMPLETE THE RELEVANT SECTIONS.

Please tick the appropriate box.

ADD DEPENDANT ☐	Complete sections 1.1, 3 and 4
TERMINATION OF MEMBERSHIP ☐	Complete sections 1.2 and 4
MARRIAGE (CHANGE OF SURNAME) ☐	Complete sections 1.3 and 4
DEATH OF MEMBER ☐	Complete sections 1.4, 1.6 and 4
CONTINUATION OF MEMBERSHIP ☐	Complete sections 1.5, 1.6 and 4
BANKING DETAILS ☐	Complete sections 1.6 and 4

1.1 ADD DEPENDANT **Please provide membership certificates of previous medical schemes and marriage and/or birth certificates, where applicable. Please complete the medical history section for your dependant(s).**

Dependant	Initials	First name	Surname	ID number or date of birth	Relationship	Gender	Adult/Child	Race*
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 and a certificate of membership.

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

Add dependant(s) with effect from D D M M Y Y Y Y

1. CHANGES IN MEMBERSHIP DETAILS (CONTINUED)

1.1 ADD DEPENDANT (CONTINUED) **Please provide membership certificates of previous medical schemes and marriage and/or birth certificates, where applicable. Please complete the medical history section for your dependant(s).**

Please note:
Any dependant over 21 will **not** qualify 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 they are:
  - unmarried
  - mentally and/or physically disabled
  - not a beneficiary of another registered medical scheme.

For a spouse, partner or other dependants who are 18 years and older, please complete the contact information fields (cell phone number, email address and physical 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

Physical address

Code

Race* African Coloured Indian/Asian White Other

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

Physical address

Code

Race* African Coloured Indian/Asian White Other

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

1.2 TERMINATION OF MEMBERSHIP **Effective date** D D M M Y Y Y Y Member Dependant

Member/Dependant	Initials	First name	Surname	ID number or date of birth	Reason for termination

1.3 MARRIAGE **Change of surname in the event of marriage, if applicable.**

New surname

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

1. CHANGES IN MEMBERSHIP DETAILS (CONTINUED)

1.4 DEATH OF MEMBER Transfer of principal membership following death
(PLEASE PROVIDE A COPY OF THE DEATH CERTIFICATE)

Details of deceased principal member

Surname

First names

Membership number

Details of new principal member

Surname

First names

Identity/Passport number

Income tax reference number

Contact numbers Home 0 Work 0

Cell phone 0

Email address

Physical address

Code

1.5 CONTINUATION OF MEMBERSHIP To be completed in the event of a member retiring from the service of their Employer or employment being terminated on account of ill-health or other disability.

Date of retirement D D M M Y Y Y Y

Employee number

1.6 BANKING DETAILS

Important notes:

- Your banking details will only be processed upon receipt of a valid copy of your identity document, together with a letter stamped by your bank or a bank statement validating your banking details.
- First National Bank savings accounts cannot be directly debited.
- Please do not provide credit card details. The Wooltru Healthcare Fund cannot process debit orders from your credit card.

Banking details of applicant (only if member pays the contributions)

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account

Please use this account for claims refunds Yes No

Signature of account holder

Wooltru Healthcare Fund may debit the above account with the contribution amount due under the contract in accordance with the Wooltru Healthcare Fund debit order system. I/We agree to inform Wooltru Healthcare Fund in writing of any changes that take place. I/We authorise Wooltru Healthcare Fund to verify such account details with the financial institution. I/We accept that Wooltru Healthcare Fund may debit the account on a date other than the date specified.

1. CHANGES IN MEMBERSHIP DETAILS (CONTINUED)

1.6 BANKING DETAILS (CONTINUED)

Banking details of applicant (for claims refunds, if it is different to the banking details above)

This section must only be completed if claims refunds should be paid into an account other than the account above.

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account

Please use this account for claims refunds Yes ☐ No ☐

Signature of account holder

2. TERMS AND CONDITIONS

A. GENERAL

Membership of the Wooltru Healthcare Fund (the Fund) is a compulsory condition of employment unless you belong to your spouse's medical scheme. New employees have 30 days from the date they become eligible within which to apply for membership of the Fund 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 unmarried 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 dependant 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 may I obtain the relevant affidavits mentioned?
The relevant affidavits may be obtained from your HR representative or printed from the Employer's intranet.

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 **0802 228 922**.

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 die
- your address or contact details change
- your children no longer qualify for dependant 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

The Medical Schemes Act 131 of 1998 introduced certain waiting periods and exclusions to protect medical schemes from anti-selection by its members.

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 employer.

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.

2. TERMS AND CONDITIONS (CONTINUED)

B. WHEN WAITING PERIODS ARE APPLIED (CONTINUED)

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 the Fund;
- was a member of a medical scheme for less than two years before applying to join the Fund.

C. WAITING PERIODS

The following waiting periods are allowed in terms of the Medical Schemes Act 131 of 1998:

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 arrears, 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 dependants;
- 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 dependants 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.

3. 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.

DEPENDANT'S NAME	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
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 medical condition. Please provide names of medications.				
Allergies				
Arthritis, limb or back problems				
Asthma or any other respiratory disorder				
Blood disorders				

3. MEDICAL HISTORY OF ADDITIONAL DEPENDANTS (CONTINUED)

DEPENDANT'S NAME	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
Cancers				
Dermatitis or other skin disorder				
Diabetes, thyroid disease				
Fits/Epilepsy				
Heart conditions				
High blood pressure				
HIV and other auto-immune conditions				
Kidney and urological disease				
Menopause				
Nervous or mood disorders				
Raised cholesterol				
Stomach or abdominal complaints				
Other (details)				

4. DECLARATION

I, the undersigned, hereby make application to be admitted as a member of the Wooltru Healthcare Fund and, if admitted, agree to abide by the constitution and Rules of the Fund. 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 FUND MAY BE DEDUCTED FROM MY SALARY;

(b) THAT, IN THE EVENT OF MY WITHDRAWAL FROM THE FUND, ANY AMOUNTS DUE BY ME TO THE FUND, MAY BE DEDUCTED FROM ANY MONIES DUE TO ME FROM THE EMPLOYER;

(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 Fund; and

(d) That, should I or any of my dependants require hospitalisation, I agree to provide access to the information required by the Fund.

I acknowledge that medical information will be reviewed by clinical staff employed by the Fund's Administrator, Momentum Health (Pty) Ltd, 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 _____ **Date** D D M M Y Y Y Y

07/2026