MEMBERSHIP APPLICATION FORM

FOR MOMENTUM HEALTH USE ONLY													
Membership number		Reference		Date	D	D	M	M	Y	Y	Y	Y

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS.

It is important to complete all sections of this form in full. Failing to do so will cause a delay in the processing of your application. Incomplete forms will be returned to the applicant.

SECTION A: EMPLOYER DETAILS

TO BE COMPLETED BY THE EMPLOYER

Company ☐ Woolworths ☐ Truworths ☐ Woolworths Financial Services (WFS)

Branch number | Branch name

Telephone number | Previously employed as a Flexi-timer? ☐ Yes ☐ No

Employee number

Date of employment D D M M Y Y Y Y | Join date D D M M Y Y Y Y

If there is a difference between the date of employment and the join date, please provide a reason:

Employer's signature | **Date** D D M M Y Y Y Y

☐ **This completed form has been checked and verified by the employer.**

SECTION B: EMPLOYEE/PRINCIPAL MEMBER DETAILS (COMPULSORY TO COMPLETE)

SECTION B - SECTION I: TO BE COMPLETED BY THE EMPLOYEE/PRINCIPAL MEMBER

Title | Initials | Gender ☐ Male ☐ Female

First names

Surname

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

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widow/er

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

*Optional information (not compulsory to complete) required by the Council for Medical Schemes (CMS) for statistical purposes.

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

SECTION C: DEPENDANT DETAILS

Please provide a marriage certificate and birth certificates, as required for each dependant.

For spouse/partner/dependants who are 18 years and older, please complete the contact information fields (contact number, postal address and email address). See **SECTION H: TERMS AND CONDITIONS** on page 4 for dependant classification and the proof that is required in each instance. **If you have more dependants than this form provides for, please complete SECTION C: DEPENDANT DETAILS on page 2 on an additional membership application form, and include it with your application.**

Spouse/Partner

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

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

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

Contact number | Relationship to applicant (e.g. wife)

Postal address

Postal code

Email address

Dependant 1

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

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

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

Contact number | Relationship to applicant (e.g. son)

Postal address

Postal code

Email address

Dependant 2

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

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

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

Contact number | Relationship to applicant (e.g. son)

Postal address

Postal code

Email address

Dependant 3

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

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

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

Contact number | Relationship to applicant (e.g. son)

Postal address

Postal code

Email address

*Optional information (not compulsory to complete) required by the Council for Medical Schemes (CMS) for statistical purposes.

SECTION D: OPTION SELECTION

☐ **NETWORK OPTION**

Please tick your monthly income below:

- ☐ R0 - R11 800
- ☐ R11 801 - R14 500
- ☐ R14 501+

Your Network GP	Practice number
Your Network dentist	**Practice number**

☐ **SAVER OPTION (Member restricted to use Mediclinic or Netcare hospitals)**

☐ **SAVER CHOICE OPTION (Member may use any hospital)**

☐ **COMPREHENSIVE OPTION (Member may use any hospital)**

SECTION E: BANKING ACCOUNT DETAILS FOR MEDICAL CLAIMS REFUNDS

Name of bank

Branch name

Branch code

Account number

Type of account

Please include the following supporting documents along with this membership application:

- A copy of the principal's member identity document (ID)
- Stamped bank statement or a bank account confirmation letter.

SECTION F: MEDICAL SCHEMES' HISTORY

Please provide certificates of membership for the principal member and all dependants to be registered on the Fund.

Name of medical scheme	Membership number	Main member or dependant?	Join date	Termination date	Duration of cover (Years/Months)	
			D D M M Y Y Y Y	D D M M Y Y Y Y	Years	Months
			D D M M Y Y Y Y	D D M M Y Y Y Y	Years	Months
			D D M M Y Y Y Y	D D M M Y Y Y Y	Years	Months
			D D M M Y Y Y Y	D D M M Y Y Y Y	Years	Months
			D D M M Y Y Y Y	D D M M Y Y Y Y	Years	Months

SECTION G: MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS

Please provide details for each applicable answer in the columns below.

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by you and your dependants. Should you not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

	Principal member	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3
Member/Dependant name					
1. Details of any ongoing medical treatment received for any conditions in the past 12 months.					
2. Will any of the above require an operation in the near future?					

SECTION G: MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS (CONTINUED)

	Principal member	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3
Member/Dependant name					
3. Pregnant?					
Expected date of delivery	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
4. Details of any chronic conditions and any related medication being taken.					
Allergies					
Arthritis, limb or back problems					
Asthma or any other respiratory condition					
Blood disorders					
Cancers					
Dermatitis or other skin condition					
Diabetes, thyroid disease					
Fits/epilepsy					
Heart conditions					
High blood pressure					
Kidney and urological disease					
Menopause					
Nervous or mood disorders					
High cholesterol					
Stomach or abdominal complaints					
Other					

Please note: Your HIV status should not be disclosed in this form. To enrol on our YourLife Programme for HIV management, please contact **0860 109 793** or email **hiv@momentum.co.za**. **All correspondence is 100% confidential.**

SECTION H: TERMS AND CONDITIONS

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 to apply for membership, failing which, waiting periods will apply.

SECTION H: TERMS AND CONDITIONS (CONTINUED)

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 a member 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 supporting legal documents.
   - 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.

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

4. **Additional adult dependant**
   - An unmarried child who is 21 years or older and dependent 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 dependant rates for children under the age of 21 and adult dependant 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 family 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 providing your ex-spouse remains unmarried.
   - Upon the death of the principal member, Fund rule 6.3.6 applies.

Frequently asked questions

1. **Where can I obtain the relevant affidavits mentioned above?**
   The relevant affidavits may be obtained from your human resources (HR) representative, from your company's intranet or from the Fund's website.

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 Service Team on **0802 228 922** to 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 pass on
   - your address, contact or banking details change
   - your children no longer qualify for membership as dependants in terms of the Fund rules
   - you retire.

SECTION H: TERMS AND CONDITIONS (CONTINUED)

Waiting periods

The Medical Schemes Act 131 of 1998 ('the Act') introduced certain waiting periods and exclusions to protect medical schemes and its members.

The categories of members or employees who are subject to waiting periods are:
- current employee
- child dependant
- spouse
- additional adult
- parents of the member
- retiree.

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

1. **When are waiting periods applied?**

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

   Adding a newborn, adopted or fostered child
   No waiting periods are imposed on a newborn or an adopted child provided they are registered with the Fund 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 with the Fund 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 any medical scheme in the three months before applying to join the Fund
   - was a member of any medical scheme for less than two years before applying to join the Fund.

2. **Types of waiting periods**

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

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

   b. **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.

   c. **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

1. 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.
2. If you join on or before the 15th of a month, your first contribution will be calculated from the start of that month.
3. If you join after the 15th of a month, your first contribution will be payable from the first day of the following month.
4. Your contributions will be deducted from your salary/pension and paid to the Fund.

SECTION H: TERMS AND CONDITIONS (CONTINUED)

Pre-existing medical conditions

The Fund reserves the right to impose waiting periods as defined in the Fund 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 in **SECTION G: MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS** on pages 3 and 4 of this form, if you or any of your dependants have had one or more pre-existing medical condition(s) during the last 12 months.

SECTION I: CONSENT TO DISCLOSE INFORMATION

Protection of Personal Information

Wooltru Healthcare Fund (the Fund) requests 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 the Fund.

The Fund and Momentum Health, the Fund's administrator, will maintain the confidentiality of your personal information and will comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing your personal information for the purposes of managing your membership of the Fund and in accordance with the Act. 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 the Fund will not be able to offer you membership to the Fund.

By signing the declaration on page 8, you agree to the Fund, Momentum Health and/or the Fund's service providers processing and disclosing your personal information as follows:

1. The collection, collation, processing, storing and disclosure of your personal information including health information, and that of all your dependants, **for the following purposes ONLY**:
   - membership to the Fund and in accordance with the Act
   - the management and administration of your Fund benefits
   - the provision of the Fund's managed care services to you and your dependants
   - 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
   - for trends 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, Momentum Health and/or the Fund's service providers will only share your personal information or that 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, unless we are required to do so by law**.

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

5. You have the right to withdraw your consent to have your personal information processed provided that the lawfulness of the processing of your personal information before your withdrawal will not be affected.

6. You have the right to object on reasonable grounds relating to your particular situation, to the processing of your personal information unless processing is required by law. You have the right to request the Fund and/or Momentum Health where necessary, to correct or delete your personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

7. If you have a complaint relating to the processing of your personal information, you agree to refer it to the Fund and to the administrator to resolve it in terms of their internal complaints process first. If you are not satisfied with the outcome of the complaint, you may refer the complaint to the Information Regulator by telephone on **010 023 5200** or by email at **enquiries@inforegulator.org.za**.

8. Your personal information will be shared between the Fund, Momentum Health and any contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to your membership of the Fund.

SECTION J: MEMBER DECLARATION AND SIGNATURE

I, the undersigned, hereby make application to be registered as a member of the Fund and, in doing so, agree to abide by the Fund rules.

I certify that the information provided in this application form is true and correct to the best of my knowledge and belief. I declare that the Fund is not responsible for any false or incorrect statement made in this application and such false or incorrect statement made in this application will render my membership null and void.

SECTION J: MEMBER DECLARATION AND SIGNATURE (CONTINUED)

I further agree to the following:

a) Any amounts due by me to the Fund may be deducted from my salary.
b) In the event of my resignation or termination from the Fund, any amounts due by me to the Fund, may be deducted from any monies due to me from the company.
c) If any amount due by me cannot be deducted as per point a) or b) above, I undertake to pay such amount directly to the Fund.
d) Should I or any of my dependants require hospitalisation, I agree to provide access to my personal and medical information as required by the Fund.

I acknowledge that medical information will be made available to and be reviewed by clinical staff employed by Momentum Health. I am also aware that certain medication and high-cost procedures will be subject to clinical review and that benefits will be approved based on medication formularies and clinical protocols.

Signature of principal member

Date D D M M Y Y Y Y

05/2026

WOOLTRU HEALTHCARE FUND

Postal address: Wooltru Healthcare Fund, PO Box 2212, Bellville 7535
Telephone: **0802 228 922**
Email: enquiries@wooltruhealthcarefund.co.za
Website: www.wooltruhealthcarefund.co.za