momentum

Health4Me Employee membership and option change form

Important notes:

- · This form needs to be completed in the event that an employee wishes to make changes to his/her current benefit option.
- Please ensure that all sections are fully completed. Incomplete information will cause a delay in the processing of your benefit option change application.

Option changes will be effective 01Please submit the completed form		mbe	rsh	ip@)mo	me	ntu	m.c	0.Z	a.					
1: Employer details															
Employer group number															
Employer group name															
2: Main member's persona	al details														
Membership number															
First name															
Surname															
Date of birth	D D M M Y Y Y	Υ								(Gender	Male		Female	
ID number									Pas	ssport num	ber				
Passport country of origin															
Cellphone number															
Email address															
3: Withdrawal of dependant Name and surname of dependant	nt/s ID/passport number	Da	ate c	of bi	irth					Reason					
		D	D	M	M	Υ	Υ	Υ	Υ						
		D	D	M	M	Y	Y	Y	Y						
		D	D	M	M	Y	Y	Y	Y						
		D	D	M	M	Y	Y	Y	Y						
Effective date												D D		YY	YY
4: Addition of dependant/s	;														
Name and surname of dependant	ID/passport number	Date of birth							Gender (M/F)	Relat	ionship	Cellp	hone nur	nber	
		D	D	M	M	Υ	Y	Υ	Υ						
		D	D	M	M	Υ	Υ	Υ	Υ						
		D	D	M	M	Y	Y	Y	Y						
		D	D D	M	M	Y	Y	Y	Y						
Effective date				1 7 1	171	<u> </u>	1	1	Ĺ.,						

Please indicate which benefits you would like to take by ticking the applicable box/es below: Add benefit Benefit option Remove benefit Day-to-day Benefit Accident Cover Hospital Cash Benefit Funeral Benefit 6: Employee application acceptance By signing this form I hereby confirm that I am aware that the requested changes will have a direct impact on the monthly premiums payable in terms of the benefits selected. Signature of employee Date Signature of employer authorised Date signatory

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Benefit grouping details