

Declaration of health

(by insured life)

Policy number

Member number*

Group number* (*Fill in for FundsAtWork)

1: General information

Name of insured life	<input type="text"/>														
Permanent identity/passport number	<input type="text"/>						Permanent identity number	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
Date of birth	<input type="text"/>	Telephone	<input type="text"/>												
Residential address	<input type="text"/>														
											Postal code	<input type="text"/>			
Occupation	<input type="text"/>														
Gross monthly income	Insured life	<input type="text"/>	Spouse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
Percentage of working hours spent on	Travelling	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	Administration	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	Supervision	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
	Manual labour	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	Industry	<input type="text"/>								
Employer	<input type="text"/>														
Description of main duties	<input type="text"/>														

2: Underwriting questions

Do you currently or have you ever suffered from any of the following?

1. Heart or blood circulation

1.1	High blood pressure	<input type="checkbox"/>	1.4	Raised cholesterol	<input type="checkbox"/>	1.7	Shortness of breath	<input type="checkbox"/>
1.2	Rheumatic fever	<input type="checkbox"/>	1.5	Chest pains	<input type="checkbox"/>	1.8	Heart murmur	<input type="checkbox"/>
1.3	Palpitations	<input type="checkbox"/>	1.6	Heart attack	<input type="checkbox"/>	1.9	Circulatory disorders of legs	<input type="checkbox"/>

Yes No

2. Respiratory and lung complaints

2.1	Asthma	<input type="checkbox"/>	2.3	Bronchitis	<input type="checkbox"/>	2.5	Any breathing problems	<input type="checkbox"/>
2.2	Tuberculosis	<input type="checkbox"/>	2.4	Persistent coughing	<input type="checkbox"/>	2.6	Other	<input type="checkbox"/>

Yes No

3. Disorders of the digestive system, gall bladder, pancreas or liver

3.1	Gall stones	<input type="checkbox"/>	3.5	Gastric ulcers	<input type="checkbox"/>	3.7	Hiatus hernia	<input type="checkbox"/>
3.2	Pancreatitis	<input type="checkbox"/>	3.6	Recurrent indigestion	<input type="checkbox"/>	3.8	Rectal bleeding	<input type="checkbox"/>
3.3	Hepatitis A/Acute hepatitis/Jaundice	<input type="checkbox"/>	3.9	Other	<input type="checkbox"/>			
3.4	History of hepatitis B or C/Chronic hepatitis/Any liver disorder	<input type="checkbox"/>						

Yes No

4. Disorders of the kidneys, bladder or reproductive organs

4.1	Protein in urine	<input type="checkbox"/>	4.3	Kidney stones	<input type="checkbox"/>	4.5	Prostate problem	<input type="checkbox"/>
4.2	Blood in urine	<input type="checkbox"/>	4.4	Bladder infection	<input type="checkbox"/>	4.6	Other	<input type="checkbox"/>

Yes No

5. Have you used any of the following drugs or medicines?

5.1	Sedatives	<input type="checkbox"/>	5.5	Tranquillisers	<input type="checkbox"/>	5.7	Anabolic steroids	<input type="checkbox"/>
5.2	Antidepressants	<input type="checkbox"/>	5.6	Cannabis	<input type="checkbox"/>	5.8	Cocaine	<input type="checkbox"/>
5.3	Chronic medication - specify (other than for disclosed conditions)	<input type="text"/>	5.9	Other	<input type="checkbox"/>			
5.4	Any homeopathic medicines	<input type="checkbox"/>						

Yes No

2: Underwriting questions (continued)

6. Nervous or mental disorders

Yes No

6.1	Anxiety	6.5	Depression	6.7	Stroke
6.2	Epilepsy	6.6	Blackouts	6.8	Paralysis
6.3	Panic attacks/Post traumatic stress disorder				
6.4	Consultation/s with psychiatrist/psychologist				

7. Any disorders of the eye, ear, nose or throat

Yes No

7.1	Defective vision (excluding conditions corrected by glasses, contact lenses or keratotomy)				
7.2	Hoarseness	7.4	Ear discharge	7.5	Other
7.3	Hearing loss				

8. Problems with the skin, muscles, bones, joints, limbs or spine

Yes No

8.1	Psoriasis	8.5	Dermatitis	8.9	Back problems
8.2	Arthritis	8.6	Gout	8.10	Fractures/Broken bones
8.3	Neck problems	8.7	Slipped disc	8.11	Other
8.4	Fibromyalgia	8.8	Rheumatism		

9. Blood, glandular or hormonal disorders

Yes No

9.1	Bleeding disorders	9.3	Diabetes	9.5	Sugar in urine
9.2	Problems with thyroid/other glands	9.4	Anaemia	9.6	Other

10. Cancer, any growth or tumour of any kind, including moles removed (malignant/benign)

Yes No

11. Female insured life

Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, or abnormal vaginal bleeding, dense breast tissue, lumps or cysts in the breasts or ovaries?

Yes No

12. Any physical or chronic disorders or tropical diseases?

Yes No

12.1	Chronic fatigue syndrome	12.4	Any chronic disease	12.5	Porphyria
12.2	Any tropical diseases, e.g. malaria, bilharzia			12.6	Other
12.3	Contract the same illness recurrently				

13. Have you sought medical advice, personal counselling or treatment for any sexually transmitted diseases?

Yes No

13.1	Gonorrhoea/Syphilis/Genital herpes	13.2	Other
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14. Any other illness, disorder, disability or accident, including motor vehicle accidents?

Yes No

15. Have you had any of the following in the past? (Excluding investigations done for conditions already disclosed)

Yes No

15.1	X-rays	15.6	ECGs	15.7	Scans
15.2	Genetic testing/Tumour markers			15.8	Received medical advice
15.3	Consultation/s with any specialists			15.9	Other
15.4	History of gastroscopy, colonoscopy or any other special examination				
15.5	Operations or have you been hospitalised (excluding tonsillectomy and appendectomy)				

16. Is any future surgery planned or do you expect to seek medical advice that you are aware of now in the next eight weeks? (Other than for medical examinations that may arise from this application.)

Yes No

If "yes", provide full details:

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If you have answered "yes" to any of questions 1 - 16 (except question 15), provide details:

Q no	Condition/impairment	Doctor's and hospital's name and address	Currently on treatment?		Date of last treatment/symptoms					Fully recovered?		
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Yes	No

2: Underwriting questions (continued)

17. **Family history. Do any of your relatives suffer from, or have they had any of the following medical conditions?** Yes No

If "yes", indicate the medical conditions below:

	Father	Mother	Brother/ Sister	Brother/ Sister	Brother/ Sister	Brother/ Sister
Age if alive	<input type="text"/>					
If deceased, age at death	<input type="text"/>					
Heart disease/Stroke/High blood pressure/Raised cholesterol	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>					
Cancer	<input type="checkbox"/>					
Other (hereditary diseases)	<input type="checkbox"/>					

Provide details if you ticked any of the conditions, including age at onset for heart disease or diabetes, and type of cancer. If "other", specify:

18. **Have you ever been tested for, or received any medical advice or personal counselling about aids or any infection by one of the HI viruses? The disclosure of previous test results does not necessarily mean that we will refuse you cover. If "yes", give details of all HIV tests you have undergone, including why the test was conducted or the advice was sought.** Yes No

Reason for the HIV test: Insurance Employment Other

If "other", provide full details:

19. **Have you received an HIV vaccine as a participant in the South African Aids Vaccine Initiative (SAVI) trial?** Yes No

20. Habits

20.1 Have you smoked or used any other form of tobacco in the past 12 months? Yes No

If "yes", provide details:

If "other", specify in the empty block and provide details:

Type	Quantity per day
Cigarettes	<input type="text"/>
Pipe	<input type="text"/>
Cigar	<input type="text"/>
Smokeless tobacco (chew/snuff)	<input type="text"/>
	<input type="text"/>

20.2 Do you consume any form of alcohol? Yes No

If "yes", provide details:

If "other", specify in the empty block and provide details:

Type and measure	Quantity per day
Beer (units/bottles)	<input type="text"/>
Wine (glasses)	<input type="text"/>
Spirits (tots)	<input type="text"/>
	<input type="text"/>

20.3 Have you ever received medical advice or participated in a rehabilitation programme to reduce alcohol and/or tobacco consumption? Yes No

If "yes", provide details:

21. Height and weight

22.1 Height (without shoes) , m Weight (clothed) kg

22.2 Has your weight changed by more than 5kg during the past year? Yes No

If "yes", provide reason:

and changed by kg

22. Do you participate in or are you involved in any pursuit, avocation or occupational activity that might be considered hazardous? Yes No

Racing Diving Aviation Parachuting Mining Occupation Other

Attach relevant questionnaire.

If "other", provide details:

2: Underwriting questions (continued)

23. Has any insurer ever declined, postponed withdrawn or accepted at any increased premium or reduced cover, or subject to an exclusion clause any application for insurance on your side? Yes No

If "yes", provide details:

24. Have you ever been medically boarded or have you submitted claims for disability or third party benefits? Yes No

If "yes", provide details:

25. Do you have any other applicable information for us? Yes No

26. Do you accept any exclusion for any health condition for this application? Yes No

If "yes", provide details of exclusions that you accept:

Current/Most recent medical doctor

Medical doctor: Under Confidential Correspondence, indicate the name of the doctor to whom we may send reasons for health loadings or results of an HIV test.

Name of medical doctor

Telephone

Postal address

 Postal code

3: Declaration and agreements

I accept and understand that I am limiting my right to privacy. However, to enable the assessment of the risks and to assist in considering any claim for benefits under this or any other application for insurance that I have made or that was made for me as the insured life, I authorise MMI Group Limited, a registered long-term insurer, including the current and future subsidiaries and/or representatives (Momentum):

- to obtain from any person or body, any information that Momentum needs in connection with this application or the policy. I also authorise and instruct such person to give the said information to Momentum, and
- to share with other insurers that information and any information in this application or in any related policy or other document, either direct or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

1. This document and any documents that were submitted in connection with it, form the basis of this contract and all information that I have supplied is correct and complete.
2. I undertake to let Momentum know in writing if a change takes place in the health, activities or occupation of the insured life/lives between the date of this application and the starting date of the policy or the acceptance date, whichever occurs last.
3. I acknowledge that Momentum will apply the standard conditions that it normally sets for this type of contract, and where applicable, the rules of the scheme to which this policy belong, and that only these conditions will bind Momentum and not the representations or undertakings that any person makes or gives.
4. I understand that Momentum requires the insured life to undergo and HIV test.
5. I consent that Momentum may inform anyone who later owns this policy if Momentum adjusts the benefits or the premium under this policy for any reason.
6. I understand that Momentum will cancel the insurance contract that was issued under this application if the insured life/lives has/have withheld any important information on this application form, or answered any question/s incorrectly, and that the policyholder will forfeit all premiums paid.
7. I acknowledge and understand that MMI Group Limited and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain if I sign this application before completing it in full. I acknowledge and understand that it is an offence to sign a blank or incomplete application form, as stated in the Policyholder Protection Rules that have been published under the Long-Term Insurance Act of 1998.
8. I understand that I may cancel or change the beneficiaries under this policy by notifying Momentum in writing and that Momentum must receive such a notice before my death for it to be effective.
9. I accept all legal risks associated with communicating with Momentum via the electronic medium that I chose in this communication, and I indemnify and hold Momentum harmless against any consequent loss that I or any third party may suffer as a result of the misuse, misapplication, or misinterpretation of this communication. In the event of a conflict between the contents of this communication and any subsequent written instruction of the policyholder, this communication will take precedence, and will be binding on the policyholder, provided that this communication has been properly completed and is regular on the face of the document.

3: Declaration and agreements (continued)

10. Where Momentum is liable to pay interest on any amount/s owed in terms of this contract, Momentum will determine the rate of interest to be applied in accordance with Momentum's business practice from time to time.
11. I acknowledge that I have read the declaration above, that I fully understand the nature and effect of it and that it will bind me.

Signed at

Signature of insured life

Date

D	D	M	M	Y	Y	Y	Y
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