

Individual health assessment consent form

Important notes

Multiply Premier members receive one free health assessment at Dis-Chem, Clicks or Multiply-affiliated pharmacies, or Multiply wellness days per year. Multiply Premier members who have already redeemed the benefit in the calendar year, can use the medical aid benefit or pay in cash. Provider and Starter Multiply members do not receive a free health assessment and will be liable for the cost.

For GP billing purposes, please use the tariff code 969220. The health assessment tariff code is not to be billed with the consultation tariff code. For pharmacy billing purposes, please use nappi code 711326001.

Momentum Health members: Please submit completed forms to 031 580 0528 or healthreturns@momentum.co.za.

Multiply members: Please submit completed forms to multiply@momentum.co.za.

Company Date of event DD - MM - 2 0 Y Y

Name Surname

ID number YY MM DD Date of birth DD - MM - YY YY

Email address Mobile number

Medical aid name Medical aid number

Gender Male Female

Section A: Biometric information (all fields listed below are compulsory)

Height m Weight kg Cholesterol mmol/l

Blood pressure Systolic mmHg Diastolic mmHg Glucose mmol/l Pregnant Y N

Waist circumference cm (or up to 6 months postpartum)

If you are pregnant, please complete your height, weight and waist circumference. We will not use these measurements to calculate your Healthy Heart Score.

I consent that

The biometric results will be disclosed to MMI Multiply (Pty) Limited (Multiply), a subsidiary of MMI Group Limited and my associated medical aid/ medical aid administrator.

I understand the purpose and benefit of such a test

The purpose is to enable Multiply to allocate points to me that will determine my status and my associated medical aid will store the data on their database to assess my health risk. Both these entities will keep the results confidential and will not disclose results to third parties without my consent and will implement security measures against unauthorised processing by any third party.

Indemnity

I understand that MMI Group of companies, its directors and its employees will not accept any responsibility and shall not be liable for any injury, death, illness, loss or other damages of any nature (direct or indirect, special or consequential) suffered or incurred during or resulting from my participation in the aforementioned tests and the use of the results thereof. I have read and understood the above consent, purpose and indemnity.

Signature _____ Date DD - MM - 2 0 Y Y

Section B: Smoker / Non-smoker declaration

Smoker Y N

Signature _____ Date DD - MM - 2 0 Y Y

Section C: Sign-off (to be completed by the health professional)

I declare that I have tested and counselled the above member

Health professional name

Health professional signature Date DD - MM - 2 0 Y Y

Health professional registered number

Contact number