

OPTION SELECTION FORM

Please only complete this form should you wish to change your option. The option change must be approved by the employer (where applicable). Benefits are also available on the website for ease of reference www.mhcmf.co.za.

The form must be returned to the Scheme by not later than 31 December 2019 and can be faxed or emailed. For a copy of the Scheme rules, please contact Moto Health Care on 0861 000 300.

SECTION 1: PERSONAL DETAILS OF MEMBER

Membership First names Surname Identity numl]]]		
SECTION 2: YOUR OPTION SELECTION FOR 2020 (please indicate with an X which option you prefer – only one may be selected)																												
OPTIMUM CLASSIC										HOSPICARE																		
сизтом									ESSENTIAL																			
Please attach	a copy of paysli	o/pro	of of	inco	me									Pl	lease	attac	h a c	ору	of pa	yslip/	proo	f of iı	ncom	е				
		Cu	stom	n inco	ome k	and	s							Essential income bands														
0 - R3 200	R3 201 - R5 80) R	5 80	1 - R8	8 500	R	R8 501 - R10 500					> R10 501 +			0 - R3 000 F			R3 001 - R6 500			R6	R6 501 - R9 500				> R9 501 +		
SECTION 3	SECTION 3: PERSONAL INFORMATION UPDATES																											
Telephone number (home)								one number (work)																				
Cell phone number															Fax number													
Email address								\square																				
Physical address																												
																				Pos	stal co	ode						
Postal addres	irst names																											
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PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION WITH AN X

Email Post

If no selection is made, all correspondence will be posted.

SECTION 4: IMPORTANT NOTES

4.1 Please note that in accordance with Rule 18.2.1, option changes may be made once a year with effect from 1 January only. There will be no exception to this rule.

4.2 THE IMPORTANCE OF SELECTING THE CORRECT OPTION

Please ensure that you and your dependants understand the differences between the options. Study the member guide with particular reference to limits pertaining to those benefits that may affect you and your dependants. Benefits can be viewed on the website at www.mhcmf.co.za.

SECTION 4: IMPORTANT NOTES (continued)

- 4.3 If you do not submit your option selection form timeously, you will remain on your current option.
- 4.4 The Scheme can only provide personal and clinical information with written consent from the member. It is a contravention of the Protection of Personal Information (POPI) Act to do so without the consent of the person whose information is being requested. Please note that the Scheme will only provide information to another party where written consent has been received. The consent form is available on our website at www.mhcmf.co.za. Consent may be withdrawn in writing at any time.

SECTION 5: SIGNATURES (the Employer/HR department must sign this form unless you are an individual member)

I, the undersigned, hereby:

- 1. authorise all hospitals, health establishments, healthcare personnel, medical practitioners and any other person who has access to, or is in possession of, any medical or other information relating to me, to disclose such information to Moto Health Care on request;
- 2. agree that Moto Health Care will not be liable for any loss or damage whatsoever, including direct, indirect and consequential damage that may arise from the disclosure of any information pursuant to this consent;
- 3. acknowledge that the information disclosed will be used for the assessment of any claim and to conduct clinical and financial risk management;
- 4. acknowledge that this consent will continue in force until expressly withdrawn even when changing practitioners;
- 5. I acknowledge that my dependants over the age of 12 years are aware that information regarding their health can be submitted to Moto Health Care.

Member signature					D	ate	D	D	-	М	М	-	Y	Y	Y	Y
Employer/HR department signature					Da	ate	D	D	-	М	М	-	Y	γ	γ	Y
Designation of person signing																