PO Box 2338, Durban 4000
Tel: 0861 000 300
Fax: 031 580 0478
Email: membership@mhcmf.co.za

MEMBER CONSENT FORM

AUTHORISATION FOR MOTO HEALTH CARE AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

Important notes:

- Complete this form should you wish to give consent.
- Please return the completed form to Moto Health Care by fax on 031 580 0478 or via email to membership@mhcmf.co.za.

SECTION 1: MEMBER DETAILS

Member number | Identity number

First name/s

Surname

Dependant/s names

SECTION 2: TO WHOM THE INFORMATION MAY BE SUPPLIED

Financial adviser ☐

Employer representative (i.e. HR) ☐

Other third party ☐

Specify relationship

Identity number **Copy of identity document or valid passport required**

Third party consent

Title | Initials | First name

Surname

Telephone number | Cell phone number

Fax number

Email address

SECTION 3: WHAT INFORMATION CAN BE DISCLOSED

Please indicate which information Moto Health Care/the Administrator may disclose to each party:

	Financial adviser	Employer representative	Other third party
Biographical	☐	☐	☐
Benefits	☐	☐	☐
Financial	☐	☐	☐
Medical	☐	☐	☐

SECTION 4: CONSENT BY MEMBER

I, the undersigned, hereby:

- authorise Moto Health Care and the Administrator to disclose the above information to the party/parties selected;
- agree that neither Moto Health Care nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure or any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties;
- **acknowledge that this consent will continue in force until expressly withdrawn by me in writing, even if I change practitioner/employer/broker.**

Signature of member		Date	D D - M M - Y Y Y Y