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

MEMBERSHIP RECORD AMENDMENT

Important notes:
Your employer must sign this form, unless you are an individual member.
A 30 days notice period is required to terminate a principal member or dependant.

MEMBER DETAILS (this is very important)

Identity/Passport number
Member number
Member first name
Member surname
Employee number

REQUEST FOR (please tick relevant box)

- ☐ Change of contact details - **Section 1**
- ☐ Termination of dependant/s - **Section 2**
- ☐ Termination of principal member - **Section 3**

SECTION 1: CHANGE OF CONTACT DETAILS

Please advise us of your new contact details

Postal address
Postal code
Physical address
Postal code
Telephone (home)
Telephone (work)
Cell phone number
Email address
Effective date 0 1 - M M - Y Y Y Y

PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION WITH AN X Email ☐ Post ☐
If no selection is made, all correspondence will be posted.

SECTION 2: TERMINATION OF DEPENDANT/S

Please complete the information of the dependant/s that you would like to terminate.

Effective date 0 1 - M M - Y Y Y Y

DEPENDANT 1

Surname
First name
Gender M ☐ F ☐ Date of birth D D - M M - Y Y Y Y
Identity number
Relationship

Please indicate reason for termination on page 2.

SECTION 2: TERMINATION OF DEPENDANT/S (continued)

Effective date 0 1 - M M - Y Y Y Y

DEPENDANT 2

Surname

First name

Gender M F Date of birth D D - M M - Y Y Y Y

Identity number

Relationship

Reason for termination (please tick)

- Self-supporting
- Death (please supply death certificate)
- Divorce
- Marriage
- Transfer to a new medical scheme
- Overseas
- Other (please specify)

SECTION 3: TERMINATION OF PRINCIPAL MEMBER

Effective date 0 1 - M M - Y Y Y Y

Reason for termination (please tick)

- Change of employment
- Marriage
- Dismissed
- Retirement
- Transfer to a new medical scheme *
  - Name of new medical scheme
  - (required for transfer of positive savings balance, if applicable)
- Death (please supply death certificate)
- Divorced/Separated
- Financial reasons
- Retrenchment
- Left company (no longer employed)
- Relocating overseas
- Left Scheme due to DSP
- Left Scheme due to underwriting
- Left Scheme due to product
- Left Scheme due to service
- Maternity
- Transfer to new Group (**Important:** please complete a change in employer form)

* A copy of your identity document/passport document is required. **This is mandatory.**

New medical scheme membership number

If other, please specify

If your current medical scheme does not have a savings component or if you are not joining another medical scheme, please provide the banking details should you have a positive savings balance, which needs to be paid out (Moto Health Care requires confirmation of banking details from the bank):

Name of bank

Account number

Type of account Current Savings Transmission

Branch code Branch name

Would you like to continue membership with Moto Health Care? Yes No

Please provide us with your contact information in order to arrange for you to continue as a member with Moto Health Care.

Signature of account holder

Date D D - M M - Y Y Y Y

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN MEMBERSHIP

To be signed by an employer representative if the employer pays your contribution.

- I/We warrant that the principal member referred to in this application is an employee of our organisation.
- Moto Health Care may update billing for this member in the same manner as for other members that our organisation employs.

Disclaimer: I/We hereby authorise the Scheme and/or its duly authorised service providers to obtain from any person any necessary information, which relates to any aspect of Scheme membership of me and my dependants.

Name

Surname

Designation of representative

Signature of member

Date D D - M M - Y Y Y Y

Signature of employer representative

Date D D - M M - Y Y Y Y