OPTION SELECTION FORM

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

moto HEALTH CARE
taking care of our own

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. This form must be returned to the Scheme by not later than 31 December 2021 and can be faxed to **031 580 0478** or emailed to optionchange@mhcmf.co.za.

For a copy of the Scheme rules, please contact Moto Health Care call centre on 0861 000 300. Alternatively, you may view them on the website at www.mhcmf.co.za.

SECTION 1: PERSONAL DETAILS OF MEMBER

Member number

First name/s

Surname

Identity number

SECTION 2: PERSONAL INFORMATION UPDATES

Telephone number (h)

Telephone number (w)

Cell phone number

SARS income tax number

Work email address ☐

Personal email address ☐

Please tick preferred email address

Physical address

Postal code

Postal address

Postal code

Please tick your preferred method of communication. If no selection is made, all correspondence will be emailed.

Email ☐ Post ☐

SECTION 3: YOUR OPTION SELECTION FOR 2022 (Please tick the option you prefer - only one may be selected)

ESSENTIAL ☐

Please tick your income band below and attach a copy of your payslip/proof of income

ESSENTIAL INCOME BANDS			
R0 - R3 100	R3 101 - R6 650	R6 651 - R9 750	> R9 751 +

CUSTOM ☐

Please tick your income band below and attach a copy of your payslip/proof of income

CUSTOM INCOME BANDS				
R0 - R3 300	R3 301 - R5 950	R5 951 - R8 700	R8 701 - R10 750	> R10 751 +

CLASSIC ☐ **HOSPICARE** ☐ **OPTIMUM** ☐

CLASSIC NETWORK ☐ **HOSPICARE NETWORK** ☐

SECTION 4: IMPORTANT NOTES

4.1 Please note that in accordance with Scheme rule 18.2.1, option changes may be made once a year with effect from 1 January the following year. 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.

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 a continuation 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 and my registered dependants, 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 in writing 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.

Please note: Kindly ensure that the Scheme has contact details of all your dependants over the age of 18.

Member signature		Date	DD/MM/YYYY
Employer/HR Department signature		Date	DD/MM/YYYY
Designation of person signing			