APPLICATION FOR **MEMBERSHIP**

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

taking care of our own

PERSONAL PARTICULARS

APPLICANT

Title ____ Initials ____ Gender Male ☐ Female ☐

First name/s ____

Surname ____

Date of birth ____ DD/MM/YYYY

Identity/Passport number ____ Country of issue ____

SARS income tax number ____

Please tick the applicable box Single ☐ Married ☐ Common law ☐ Divorced ☐ Separated ☐ Widow(er) ☐

CONTACT DETAILS

Physical address ____

____

____ Postal code ____

Postal address ____

____

____ Postal code ____

Telephone number (h) ____ Telephone number (w) ____

Cell phone number ____

Email address ____

Please tick your preferred method of communication Email ☐ Post ☐

If no selection is made and a valid email address is provided, all correspondence and statements will be emailed. Should there be no valid email address, correspondence and statements will be posted.

SPOUSE/PARTNER

Note: A marriage certificate or affidavit confirming co-habitation or proof of customary union is required.

Title ____ Initials ____ Gender Male ☐ Female ☐

First name/s ____

Surname ____

Date of birth ____ DD/MM/YYYY

Identity/Passport number ____ Country of issue ____

Relationship ____

Telephone number (h) ____ Telephone number (w) ____

Cell phone number ____

Email address ____

Please note: The Scheme reserves the right to request additional information if required.

PERSONAL PARTICULARS (CONTINUED)

*** If a dependant is not living with you, please provide a physical address.**

Please attach a copy of each dependants ID, passport or birth certificates for children. The Scheme may contact you should there be outstanding information or if further documentation is required.

Provisions of the Protection of Personal Information Act (POPIA) which came into effect from 1 July 2020, requires that all medical schemes communicate directly with dependants who are 18 years and older.

DEPENDANT 1

First name/s

Surname | Relationship

Gender: Male ☐ Female ☐ | Contact telephone number

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 2

First name/s

Surname | Relationship

Gender: Male ☐ Female ☐ | Contact telephone number

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 3

First name/s

Surname | Relationship

Gender: Male ☐ Female ☐ | Contact telephone number

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 4

First name/s

Surname | Relationship

Gender: Male ☐ Female ☐ | Contact telephone number

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY)

Should you or your beneficiaries fail to disclose a pre-existing condition, membership of the Scheme may be terminated.

Please answer 'yes' or 'no' to each question for all dependants (insert 'Y' or 'N' into the relevant box). If 'yes', please provide detailed information of medical condition and treatment in the last 12 months for all dependant/s.

	Question	APPLICANT	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1.	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease						
2.	Cystic fibrosis						
3.	Obstructive lung disease (asthma, emphysema or COAD)						
4.	Diabetes (insulin or non-insulin dependent diabetes mellitus)						
5.	Hypo- or hyperthyroidism						
6.	Arthritis (i.e. osteo- or rheumatoid arthritis or gout) – all related musculoskeletal conditions						
7.	Osteoporosis						
8.	Gastro-oesophageal reflux disease (GORD/heartburn) or stomach/duodenal ulcers (please circle)						
9.	Immune deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies, etc.)						
10.	Anaemia or abnormalities of clotting mechanism – haemophilia, thrombosis, bleeding disorder						
11.	Hormone replacement therapy, endometriosis or ovarian cysts						
12.	Depression and/or anxiety disorders, anorexia, attention deficit disorder, Alzheimer's disease						
13.	Any nervous or mental complaint (e.g. epilepsy, blackouts, paralysis or headaches)						
14.	Glaucoma, cataracts or any other disorders of the eye						
15.	Parkinson's disease or multiple sclerosis (please circle)						
16.	Hyperplasia of prostate (BPH) or prostatism						
17.	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)						
18.	Urinary tract infection or calculi (stones)						
19.	Back or neck-related condition (lumbago, sciatica, injury, spasm, loss of limb, previous surgery)						
20.	Are you or any of your dependants pregnant? If so, how many weeks?						
21.	Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant?						
22.	Have you or any of your dependants had any surgical procedure (due to injury or illness) during the past 12 months or are you planning a surgical procedure for the following 12 months?						
23.	Are you or any of your dependants on any medication at present as a result of an injury or illness?						
24.	Is there any other condition, symptom, injury or illness, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical scheme claim within the next 12 months?						
25.	Skin conditions/disorders (e.g. acne, eczema, psoriasis, etc.)						
26.	Ear, nose or throat disorders (e.g. ear discharge, recurrent tonsillitis, hearing/speech impediments)						
27.	Infectious diseases (e.g. tuberculosis, shingles, measles, etc.)						
28.	Malignant neoplasms (cancer, growths or malignant tumours)						

Medical history questions continued on page 4

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

Please answer 'yes' or 'no' to each question for all dependants (insert 'Y' or 'N' into the relevant box). If 'yes', please provide detailed information of medical condition and treatment in the last 12 months for all dependant/s.

	APPLICANT	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
29. Benign neoplasms (non-malignant tumours/growths)						
30. Specialised dentistry, maxillofacial treatment, dental problems, gum disease						
31. Have you or any of your dependants had or are you expecting to have plastic or reconstructive surgery?						
32. Any hereditary or congenital conditions, e.g. Down's syndrome						
33. Connective tissue disorders, e.g. systemic lupus						
34. Do you or your dependants take part in any professional or dangerous sports?						
35. Any other symptoms, injury or illness that were not specifically diagnosed by a doctor or for which no specific treatment was provided for any of my dependants or myself.						
36. Are you or your dependants aware of any medical condition, injury or illness that may impact your membership during the next 12 months?						

Note: Should you or any of your dependant/s have a condition that is not listed above, please can you provide details of the condition in the block below.

* Should you or any of your dependant/s be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership number, **you have 14 working days to email (ha@mhcmf.co.za) or fax (012 675 3848) confirmation of your HIV/AIDS status to our HIV/AIDS Department** to allow registration on the HIV Management Programme. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation. **This information will be treated in the strictest confidence.**

Contact details:
Telephone: 0860 109 793 (for HIV registration and/or declaration) Fax number: 012 675 3848 Email address: ha@mhcmf.co.za

Please provide details below if you have answered **'yes'** to any of the medical history questions.

Question number	Name of patient	Diagnosis	Date diagnosed	Date of last treatment and/or hospitalisation	Name of doctor, hospital or institution	Treatment recommended: likely date and duration of treatment

1. Waiting periods and penalties may be applied to this application for you and your dependant/s.
2. Please note that this medical questionnaire does not constitute an application to register, authorise chronic medication, prescribed minimum benefit (PMB) services or planned procedures. You need to obtain authorisation for these by contacting 0861 000 300 once your membership has been finalised.
3. For further details please refer to the latest member guide.
4. Failure to disclose any pre-existing conditions could result in limited benefits or the exclusion of benefits or the termination of your membership.

BANKING DETAILS OF APPLICANT (ONLY IF MEMBER PAYS THE CONTRIBUTIONS) - *Please see important note on page 11

Please do not provide credit card details. Moto Health Care is not allowed to record your credit card details.

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

Please use this account for claims refunds Yes ☐ No ☐

Signature of account holder

BANKING DETAILS OF APPLICANT (FOR CLAIMS REFUNDS IF IT IS DIFFERENT TO THE DETAILS ABOVE)

This section must only be completed if claims refunds should be paid into an account different from the account above.
Please do not provide credit card details. Moto Health Care is not allowed to record your credit card details.

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

Signature of account holder

ONLINE ACCESS TO MEDICAL INFORMATION

This is for web registration to access your profile, which has your claim statements, claims processed, authorisations, etc.

Would you like access to your information on the Moto Health Care website? Yes ☐ No ☐

Email address

Preferred username

1. I accept that Moto Health Care will not in any way be responsible or liable for any claims of any nature whatsoever made by anyone (myself excluded), which arise as a result of my failing to keep my password and username secure and confidential to myself.
2. I indemnify Moto Health Care against any such claims.
3. I understand that this service may not be available 24 hours a day.

OPTION SELECTION (PLEASE TICK THE OPTION YOU PREFER - ONLY ONE MAY BE SELECTED)

Please attach a copy of your payslip or proof of income if you have selected the Custom or Essential Option. This is mandatory.
Should your income information be omitted, your contribution will be defaulted to the highest income band.

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** ☐

EMPLOYER INFORMATION

Name of employer		
Employer number		
Applicant's employee number		
Applicant's occupation		
Date of permanent employment		DD/MM/YYYY
Date membership is to start		**01**/MM/YYYY
Income/Salary	R	
Business telephone number		
Employer email address		

ALL INFORMATION PROVIDED HEREIN IS CERTIFIED CORRECT

It is hereby confirmed that the applicant is in our employ and commenced employment on the date indicated above.

Signed on behalf of the employer		Date	DD/MM/YYYY
Name of signatory			
Designation			

DETAILS OF FINANCIAL ADVISOR (WHERE APPLICABLE)

Broker name	
Broker number	
Brokerage name	
Brokerage number	

Signature		Date	DD/MM/YYYY

Disclaimer: The Scheme will only pay the agreed commission to the Scheme's accredited brokerages.

The Scheme has an agreement with certain brokerages and not with individual brokers. Commission is therefore paid to the accredited brokerage for the servicing of members.

WAITING PERIODS AND PENALTIES

Moto Health Care reserves the right to underwrite all applications according to the rules and regulations set out in the Medical Schemes Act (Act 131 of 1988) that prevail at the time of the application. These include the imposition of a three-month general waiting period (all benefits) and/or a 12-month waiting period on pre-existing sickness conditions, and late-joiner premium penalties. The calculation of late-joiner penalties will be recalculated from the time such evidence is provided.

The Board of Trustees is entitled to alter or rescind any rule or annexure in terms of the Scheme rules.

PREVIOUS MEDICAL SCHEME INFORMATION OR PRINCIPAL MEMBER, SPOUSE AND DEPENDANTS

Please detail previous medical scheme membership and attach certificates of membership (membership cards are not accepted), which are required in order to avoid late-joiner penalties, waiting periods and condition-specific exclusions. Once you have received confirmation that your membership to the Scheme has been accepted, you need to resign from your current medical scheme as it is illegal to belong to more than one medical scheme at the same time. It will remain the members responsibility to ensure that his or her previous medical aid has been terminated and that there is no dual membership.

Previous medical scheme information continued on page 7

PREVIOUS MEDICAL SCHEME INFORMATION OR PRINCIPAL MEMBER, SPOUSE AND DEPENDANTS (CONTINUED)

Has there been a break of more than 90 days since resigning from your previous medical scheme? Yes ☐ No ☐

Have you had continuous membership for the last 24 months? Yes ☐ No ☐

Name of scheme	Membership number	Join date	Termination date	Name of employer	Reason for leaving

TERMS AND CONDITIONS

1. **Rules of the Scheme**

   1.1 The rules of the Scheme are available at www.mhcmf.co.za, or can be requested by post or at the registered office of the Scheme.
   1.2 I apply for my dependant/s to join Moto Health Care ('the Scheme'). I have familiarised myself with the rules of the Scheme and bind myself and my dependant/s thereto.
   1.3 The rule of construction that a contract shall be interpreted against the party responsible for the drafting or preparation of the contract shall not apply.
   1.4 No amendment of this contract, including this clause, shall be of any force or effect, unless such amendment is made in writing and signed by both parties.
   1.5 No concessions by any party shall be considered to be a waiver or novation of such party's rights in terms of this contract and shall at all times be made without prejudice of such party's rights.

2. I acknowledge that if I or my dependant/s do not disclose all the information, which is relevant to the assessment of this application, it will render any contracts to which this application relates null and void. In such an event, the Scheme must refund all contributions and will have the right to reclaim any amounts that it may have paid to me, my dependant/s or any person on my or my dependant/s' behalf under such contracts.

3. **Disclosure of information**

   3.1 In accordance with the Promotion of Access to Information Act (PAIA), the Scheme rules provide for all members to obtain relevant information from the Scheme and Administrator. Members must complete the member consent form if they are not able to access the relevant information on the Scheme's website. The registered Scheme rules, as well as the latest annual financial statements submitted to the Council for Medical Schemes and approved by members at the Annual General Meeting, are available on our website at www.mhcmf.co.za. Members can also obtain copies, at a nominal cost, at any of the walk-in centres listed in the member guide or by requesting an electronic version from a customer service agent on 0861 000 300.
   3.2 The Scheme and its duly authorised service providers 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 member. Please note that the Scheme will only provide information to another party where consent has been received. The member consent form is available on our website at www.mhcmf.co.za.
   3.3 I am familiar with the conditions and the benefits of the option selected notwithstanding representation by any other party.
   3.4 I will notify the Scheme if any alteration takes place in any circumstances on which the Scheme based its assessment of its risk after the date of this application and before the date of the Scheme's acceptance of the risk (for example, prior to the birth of a dependant on the date of this application). I acknowledge that failure to do so will render any contracts to which this application relates null and void. In such an event, the Scheme must refund all contributions and will have the right to reclaim any amounts that it may have paid to me, my dependant/s or any person on my or my dependant/s' behalf under such contracts.

   If you would prefer not to disclose the nature of any medical conditions due to confidentiality, you may wait until you have received your valid Moto Health Care membership number. On receipt of your membership number, you may contact the call centre on 0861 000 300 in order to notify us that you or your dependants have a medical condition. You will be asked to complete and return a separate Declaration of Health form. This information will be kept confidential. The responsibility will rest with the principal member to keep his or her dependants informed that they need to contact Moto Health Care to disclose any medical condition they have and for which they are receiving treatment.

Terms and conditions continued on page 8

TERMS AND CONDITIONS (CONTINUED)

☐ Please tick here to indicate that you have read the disclaimer and that the same information has been shared with all your dependants included on the application form.

Signature		Date	
			DD/MM/YYYY

4. I am aware that the Scheme may ask for proof of identification at any stage.

5. It is my responsibility to ensure that the Scheme receives the monthly contribution for my membership as well as the membership of my dependant/s.

   5.1 Non-receipt by the Scheme of one month's contribution will result in suspension of medical benefits to me and my dependant/s. Such suspension will last until all arrear contributions have been brought up to date.
   5.2 Non-receipt by the Scheme of two months' contributions will result in cancellation of my and my dependant/s' membership to the Scheme.

6. If my employer is responsible to pay my medical scheme contributions, I have authorised and instructed, alternatively hereby authorise and instruct, my employer to:
   - deduct from my remuneration (and any other sums due to me) any amounts that I may owe to the Scheme from time to time; and
   - pay such amounts to the Scheme.

   6.1 I have authorised and instructed, alternatively hereby authorise and instruct any person (for example your employer), who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in clause 7.1 to the Scheme as and when it is due.

7. All sums owing to the Scheme will be paid on demand. Failure to pay any debt due to the Scheme may result in the suspension or cancellation of my or my dependant/s' membership and/or handover to a third party for debt collection.

   7.1 I will pay all legal costs that may be incurred by the Scheme due to the recovery of any amount, which I may owe to the Scheme or any other dispute of whatsoever nature which may arise from this application or the rules of the Scheme on an attorney and client scale.

8. The information that I have provided herein is complete and true. I understand that if my dependant/s or I am accepted as members of this Scheme, my answers herein provided will form the basis of such membership.

   8.1 The acceptance of this application as well as my continued membership or that of my dependant/s is further dependent on my and my dependant/s submission to any examination by the Scheme's medical assessor as and when the Scheme requires.

9. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme.

10. The acceptance of my membership as well as the membership of my dependant/s is dependent on my provision of all information and evidence, currently and in future, to the Scheme as it may require from time to time.

    10.1 The Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that exists on the date of the Scheme's acceptance of risk.
    10.2 I hereby authorise the Scheme and duly authorised service providers to obtain from any person any necessary information which they in their sole and absolute discretion may require concerning:
    10.2.1 any claim or risk assessment in relation to this application;
    10.2.2 my medical scheme membership;
    10.2.3 the medical scheme membership of my dependant/s.
    10.3 I hereby authorise and direct any person in possession of the above information or evidence to provide same to the Scheme and duly authorised service providers on request.
    10.4 I hereby authorise any medical doctor or other provider who attended to me or my dependant/s in the past or who will attend to me or my dependant/s in future, to provide the Scheme and duly authorised service providers with such information it may require on request.
    10.5 For purposes of providing any of the above information or evidence, I hereby waive the provision of any law restricting the provision of such information.

Terms and conditions continued on page 9

TERMS AND CONDITIONS (CONTINUED)

11. In the case of new members of the Scheme, the following may apply:
    - A three-month general waiting period.
    - A 12-month exclusion on a pre-existing condition.
    - Late-joiner contribution penalty.

12. **Pre-authorisation**
    - I will notify the Scheme should any of my dependant/s require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a co-payment payable by the Scheme for any procedure undertaken.
    - No benefit will be payable by the Scheme unless it is satisfied by the validity of a claim and it has received all information required.

13. I undertake to provide 30 days' written notice to the Fund (refer to Scheme rule 14.3) should I wish to terminate my membership or that of my dependant/s.

14. I undertake to obtain the necessary consent from any of my dependant/s to whom these conditions may apply and hereby indemnify the Scheme and/or Administrator against any claim which may arise as a result of my failure to do so.

15. Words used in this application have the meaning that the rules give them.

16. I consent to the recording of all conversations between me, my dependant/s and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I further consent to all these records remaining the sole property of the Scheme and the Administrator.

17. If my dependant/s and myself are accepted as members, the registered rules of the Scheme are binding on me and my dependant/s.

18. I acknowledge that my dependant/s over the age of 12 years are aware that information regarding their health can be submitted to Moto Health Care.

19. I acknowledge that me and/or my dependant/s are also aware and fully understand the abovementioned.

20. Where the applicant or his or her dependant produces evidence of creditable coverage after a late-joiner penalty has been imposed, Moto Health Care shall recalculate the penalty and apply such revised penalty from the time such evidence is provided.

21. When a member terminates his or her membership with the Scheme and there is a balance owing to the Scheme advancing the personal medical savings account (PMSA) limit, the balance owing to the Scheme, due to the Scheme advancing the MSA, must be refunded not later than four months after termination of membership. The Scheme reserves the right to debit the member's bank account should the amount owing not be paid after four months.

22. A member shall notify the Scheme within 30 days of any change of address. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member's neglecting to comply with the requirements of this rule.

CONSENT FOR MOTO HEALTH CARE TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Moto Health Care. Moto Health Care and the Administrator, Momentum Health Solutions (Pty) Ltd, a division of Momentum Metropolitan Life Limited, will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Moto Health Care will not be able to administer or offer you membership of the medical scheme. Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to Moto Health Care and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Moto Health Care membership risk profiling and management, administration of my membership and as set out in this section.

   Moto Health Care or the Administrator may provide my personal information to any natural or juristic person, (which could include a company, corporation, state, or agency of a state, association, trust or partnership) if a contractual relationship exists between Moto Health Care or the Administrator which requires them to do so.

Consent for Moto Health Care to process personal information continued on page 10

CONSENT FOR MOTO HEALTH CARE TO PROCESS PERSONAL INFORMATION (CONTINUED)

2. If I have consented to the disclosure of my personal information, Moto Health Care or the Administrator may provide my personal information to any natural or juristic person, (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Moto Health Care or the Administrator, which requires them to do so.

3. I acknowledge that I must give Moto Health Care and the Administrator all information and evidence they may require from time to time. I authorise Moto Health Care and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Moto Health Care may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of Moto Health Care and risk profiling or management. I consent to that person providing, and instruct that person to provide, Moto Health Care and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.

4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.

5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.

6. I have the right to request my personal information, which is in the possession of Moto Health Care and the Administrator, provided that I furnish adequate identification.

7. I have the right to request Moto Health Care and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Scheme to resolve in terms of their internal complaints process first. The email address is complaints@mhcmf.co.za. If I am not satisfied with the outcome of the complaint, I understand that I refer the complaint to Information Regulator who can be contacted on 021 406 4818 or via email at inforeg@justice.gov.za.

9. My personal information will be shared between Moto Health Care, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to my membership of Moto Health Care, and
   - to grant me access to interact with Moto Health Care on its website; and
   - to provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangements or judgements obtained for outstanding debts).

DECLARATION BY THE APPLICANT

- The answers given herein are full, complete and true and, if I am accepted as a member of Moto Health Care, will constitute the basis of my membership.
- I realise that I must submit evidence of the good health of myself and my dependant/s and that benefits may be limited or excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date.
- I am bound now, and in the future, if my dependant/s and myself are accepted as members, to give Moto Health Care all such information and evidence as Moto Health Care may from time to time require and to this end authorise the medical practitioner or other provider who has attended to me in the past or who will attend to me in the future, to provide Moto Health Care with such information as Moto Health Care may require, hereby waiving the provisions of any law or regulation restricting the provision of such information.
- Words used in this application shall bear the meaning ascribed to them in the Rules.
- I hereby consent to the disclosure by the Scheme of any information supplied by third parties provided that such parties agree to keep such information confidential at all times.

Signature		Date	DD/MM/YYYY

Signed by me as the applicant declaring that I have carefully read this application form and accepting that the fact that I have applied does not necessarily mean that I will be accepted as a member.

APPLICATION CHECK LIST

Important:
We are unable to process your application if it is incomplete, incorrect, or you have not attached the relevant documents.

Please use the check list below as a guideline to ensure that all the relevant documentation has been provided.

- [ ] Have you completed all the sections relevant to your application?
- [ ] Have you completed the medical history section?
- [ ] Have you given us the correct contact details?
- [ ] Do we have your banking details so that we can collect your contributions and pay your claim refunds? (only applicable if you are paying your contribution)

***Important note: Your details will only be processed upon receipt of a valid copy of your identity document, together with a certified letter from your bank validating your banking details; alternatively the bank will need to stamp this completed form.**

- [ ] Have you signed and dated the form? (unsigned forms will be returned to you for signature)
- [ ] Has your employer information section been completed?

Have you given us a copy of the following documentation where applicable?

- [ ] Identity documents/passports of principal member as well as dependant/s
- [ ] Birth certificate
- [ ] Proof of full-time student registration
- [ ] Legal adoption forms (if children are adopted)
- [ ] Certificate of membership with an end date
- [ ] Marriage certificate
- [ ] Affidavit must be completed by the principal member (should any dependant/s surname differ from principal member's surname)
- [ ] Proof of income required from parents and grandparents for the addition of a grandchild
- [ ] Copy of cancelled cheque or copy of bank statement or certified letter from your bank validating your banking details