DECLARATION OF **HEALTH**

moto HEALTH CARE
taking care of our own

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

To be completed where date of initial application received exceeds 30 days.

Important:

- Please ensure that your membership on your previous medical aid scheme is cancelled once you have received notification of acceptance from Moto Health Care (if applicable).
- Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

Member number

Identity/Passport number

Country of issue

Current state of health

Have you or any of your dependant/s sought or received medical advice or treatment for any medical condition or illness since the date of your application to Moto Health Care **OR** have you or your dependant/s had any symptoms or received treatment for an illness that has not yet been diagnosed since the date of your application to Moto Health Care.

No ☐ **Please complete Section 1** **Yes** ☐ **Please complete Section 2**

SECTION 1: NO CHANGE IN HEALTH

I hereby declare that there has been no change in my health, my spouse's or my dependant/s' health status since the date of my application to Moto Health Care.

Name of principal member

Start date of membership **01** **01**/MM/YYYY

Signature

Date DD/MM/YYYY

SECTION 2: UPDATED MEDICAL HISTORY (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.

	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)						

Updated medical history continued on page 2

SECTION 2: UPDATED MEDICAL HISTORY (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
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)						
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?						

Updated medical history continued on page 3

SECTION 2: UPDATED MEDICAL HISTORY (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

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

Name of principal member

Signature

Date

DD/MM/YYYY