MEMBER CONSENT FORM

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

moto HEALTH CARE
taking care of our own

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 by email to membership@mhcmf.co.za.

SECTION 1: MEMBER DETAILS

Member number

Identity/Passport number | Country of issue

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 ☐

Please specify relationship

Identity/Passport number | Country of issue

Copy of identity document or valid passport of the third party is required

Third party consent

Title | Initials

First name/s

Surname

Telephone number | Fax number

Cell phone number

Email address

SECTION 3: WHAT INFORMATION CAN BE DISCLOSED

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

Time period for which consent will be valid: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Please note: If a time period is not specified, the consent will commence on the date of signature and will continue until withdrawn in writing.

	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- **acknowledge that this consent will continue in force until expressly withdrawn by me in writing, even if I change practitioner/employer/broker.**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	DD/MM/YYYY