MEMBERSHIP **RECORD AMENDMENT**

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

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)

Member number
Identity/Passport number | Country of issue
First name/s
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)

Physical address
Postal code
Postal address
Postal code
Telephone number (h) | Telephone number (w)
Cell phone number
Email address
Effective date **01**/MM/YYYY

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

Email ☐ Post ☐

SECTION 2: TERMINATION OF DEPENDANT/S

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

Effective date **01**/MM/YYYY **Please indicate reason for termination on page 2**

DEPENDANT 1

First name/s
Surname
Gender Male ☐ Female ☐ Date of birth DD/MM/YYYY
Identity/Passport number | Country of issue
Relationship

SECTION 2: TERMINATION OF DEPENDANT/S (CONTINUED)

Effective date _____ **01**/MM/YYYY

DEPENDANT 2

First name/s _____

Surname _____

Gender Male ☐ Female ☐ Date of birth _____ DD/MM/YYYY

Identity/Passport number _____ Country of issue _____

Relationship _____

Reason for termination (please tick)

☐ Self-supporting ☐ Marriage ☐ Divorce ☐ Overseas

☐ Death (please supply death certificate ☐ Transfer to a new medical scheme ☐ Other (please specify below)

_____

SECTION 3: TERMINATION OF PRINCIPAL MEMBER

Effective date _____ **01**/MM/YYYY

Reason for termination (please tick)

☐ Change of employment ☐ Death (please supply death certificate) ☐ Left Scheme due to DSP

☐ Marriage ☐ Divorced/Separated ☐ Left Scheme due to underwriting

☐ Dismissed ☐ Financial reasons ☐ Left Scheme due to product

☐ Retirement ☐ Retrenchment ☐ Left Scheme due to service

☐ Maternity ☐ Relocating overseas ☐ Left company (no longer employed)

☐ Transfer to a new medical scheme * Please advise name of scheme below (this is required for transfer of positive savings balance, if applicable)

_____

☐ 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 account holder _____

Name of bank _____

Branch name _____ Branch code _____

Account number _____

Type of account Current ☐ Savings ☐

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 of Moto Health Care.

SECTION 3: TERMINATION OF PRINCIPAL MEMBER (CONTINUED)

Signature of account holder		Date	DD/MM/YYYY

SECTION 4: 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	DD/MM/YYYY
Signature of employer representative		Date	DD/MM/YYYY