EMPLOYER APPLICATION 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

SECTION 1: EMPLOYER INFORMATION

Registration date DD/MM/YYYY

Full registered name

Registration number

If the above is not applicable, please state if partnership/sole proprietor or other:

Trading name

Type of business

Physical address

Postal code

Postal address

Postal code

Contact person

Position

Telephone number Fax 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 will be emailed.

SECTION 2: EMPLOYER'S CURRENT AND PREVIOUS MEDICAL SCHEME INFORMATION

Has the employer previously been a group of Moto Health Care? Yes ☐ No ☐

If your answer is **'Yes'**, please state previous group number

Name of current medical scheme

Date joined DD/MM/YYYY

Date to be terminated DD/MM/YYYY

Name of current medical scheme

Date joined DD/MM/YYYY

Date terminated DD/MM/YYYY

Details of your company's employee base

Number of staff that your company employs

Number of principal members that Moto Health Care will cover

Will Moto Health Care be compulsory for all employees in the company with a specific group? Yes ☐ No ☐

Will Moto Health Care be compulsory for all future employees who join the company? Yes ☐ No ☐

Will the company offer any other medical scheme to employees? Yes ☐ No ☐

If **'Yes'**, name the medical scheme

SECTION 3: OPTION SELECTION (WHERE APPLICABLE, PLEASE TICK EMPLOYER'S PREFERENCE)

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: DATE OF COMMENCEMENT

This employer contract shall commence on the **first day** of _____ MM/YYYY

All eligible employees shall apply for membership of Moto Health Care with effect from the date of commencement and, where such employees are accepted as members, their admission date shall be the abovementioned date of commencement.

SECTION 5: 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.

SECTION 6: COMPANY PAYMENT DETAILS

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

Payment method EFT ☐ Debit order ☐

Email address _____

Name of account holder _____

Name of bank _____

Branch name _____ Branch code _____

Account number _____

Type of account Current ☐ Savings ☐

Moto Health Care may debit the above account with the amounts due under the specific contracts in accordance with the Moto Health Care debit order system. We agree to inform Moto Health Care in writing of any changes that take place. We authorise Moto Health Care to verify such bank details with our bank. We accept that Moto Health Care may debit our account on a date other than specified.

Name and surname _____

Designation _____

Name and surname _____

Designation _____

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SECTION 6: COMPANY PAYMENT DETAILS (CONTINUED)

Authorised signatories		Date	DD/MM/YYYY
		Date	DD/MM/YYYY

SECTION 7: DETAILS OF FINANCIAL ADVISOR

Title		Initials	
First name/s			
Surname			
Broker house			
Personal code		House code	
Telephone number		Cell phone number	
Email address			

Signature of financial advisor		Date	DD/MM/YYYY

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

SECTION 8: TERMS AND CONDITIONS

1. We hereby apply for group membership of Moto Health Care.
2. We hereby agree to participate in the benefit options as per the terms and conditions of the Scheme.
3. We agree that the rules of the Scheme, as amended from time to time, shall be binding on us. We undertake to observe and carry out (in so far as is applicable to us), our obligations in terms of the agreement with the Scheme.
4. The person signing the contract on behalf of, or as the employer, acknowledges that he has been given a set of rules.
5. The failure to draw the employer's attention to any rule shall not in any way be regarded as excusing the employer from the employer's obligation to thoroughly acquaint himself with the rules, which can be viewed on the Moto Health Care website at www.mhcmf.co.za.
6. The contract will not bind the Scheme until written acceptance is received from the Scheme.
7. We agree that no statements, promises or information made or given to us by any other persons shall be binding on the Scheme or affect its rights in any way whatsoever, unless such statements, promises and information is incorporated in writing and acceptance by the Scheme.
8. We declare and warrant that the answers to the foregoing questions are complete and true, and agree that this application shall form the basis of the agreement with the Scheme and that, if any statements are untrue, membership may be terminated, all benefits reversed and contributions shall be forfeited.
9. If required by Moto Health Care, the employer shall make payment of contributions and other amounts due to Moto Health Care by ACB, stop order or any form of electronic bank transfer, which Moto Health Care may reasonably require.
10. Moto Health Care is not obliged to pay any benefits where the member is in breach of any of the member's obligations in terms of the rules and in particular where any contribution or part thereof is in arrears.
11. The employer is the agent of the member and not of Moto Health Care in dealings between an employee and Moto Health Care.

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SECTION 8: TERMS AND CONDITIONS (CONTINUED)

12. The employer must notify Moto Health Care within 30 days of any change of address and failure to notify will absolve Moto Health Care from any liability should the employer or member's rights be prejudiced or forfeited.

13. We acknowledge that the Scheme does not accept liability for any employee until a notice of acceptance is given by the Scheme.

14. We undertake to notify the Scheme immediately if any changes, which affect the answers to the application, occur before the Scheme grants written acceptance. This will enable the Scheme to reconsider the terms of acceptance.

15. The employer warrants that there is an arrangement in place, with every Moto Health Care member of the employer, that amounts due to Moto Health Care shall be recouped by the employer from such member's income.

16. The employer shall deduct all amounts due to Moto Health Care from the remuneration due to the employee and shall be responsible for ensuring that the same is done in compliance with law. Likewise, the company shall be responsible for arranging with the employer's pension and other schemes that all sums due to Moto Health Care by the employee upon the employee's ceasing to be employed shall be paid by such pension or other scheme, direct to Moto Health Care, particularly where the employee continues as a member of Moto Health Care after ceasing to be employed by the employer. As and when the employee ceases to be a member of Moto Health Care, the employer shall pay to Moto Health Care all amounts due by the employee to Moto Health Care including but not necessarily limited to contributions, amounts paid to providers and amounts lent and advanced by Moto Health Care to the employee to assist the employee in paying for relevant health services.

17. Where the employer's membership of Moto Health Care is terminated, the employer shall ensure that the membership of all pensioners for whom the employer pays contributions to the Scheme is also terminated, notwithstanding that such pensioners are no longer employees of the employer and will be responsible for any loss or damage (particularly any underwriting loss), which Moto Health Care may suffer as a consequence of such pensioners continuing as members of Moto Health Care.

18. We agree that contributions will be paid monthly and will be submitted to reach the Scheme by no later than the third day of the month for which the amounts are due.

19. We accept that if contributions are not paid by its due date for a member, the Scheme will suspend benefits with immediate effect. If the contributions are not paid within 30 days from the suspension date, that employee's membership will be terminated.

20. We shall give the Scheme one months' written notice of our intention to withdraw our participation in the Scheme.

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

Important notes:

- Kindly ensure that all details about the employer are fully disclosed. Every question must be completed by the employer and, if the question is not applicable, please insert N/A.
- Please do not resign from your current medical scheme until you have received written notification of acceptance from Moto Health Care. Each principal member must have started employment by the date that the company joins Moto Health Care, in order to qualify for membership.
- Incomplete forms will result in membership being delayed.
- Changes to option selections may only be made annually with effect from 1 January each year.
- A copy of the Scheme rules is available on request.