

OPTION SELECTION FORM 2023



taking care of our own

PO Box 2338, Durban 4000 | Tel: 0861 000 300 | Email: optionchange@mhcmf.co.za

Important notes:

- Please complete this form only if you are changing your current benefit option.
- The option change must be approved by your employer (where applicable).
- Please return this completed form to the Scheme by email to optionchange@mhcmf.co.za by 31 December 2022.
- In accordance with Scheme rule 18.2.1, option changes may be made once a year with effect from 1 January the following year. There will be no exception to this rule.
- If you do not submit your option selection form timeously, you will remain on your current option.
- Information on benefits and the Scheme rules are available on our website at www.mhcmf.co.za, or on request from our call centre on 0861 000 300.

PRINCIPAL MEMBER DETAILS

Title	<input type="text"/>	Initials	<input type="text"/>	Membership number	<input type="text"/>
Full name and surname	<input type="text"/>				
Date of birth	<input type="text"/>	DD/MM/YYYY	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Identity/Passport number	<input type="text"/>	Country of issue	<input type="text"/>		
Marital status	<input type="text"/>	SARS income tax number	<input type="text"/>		
Physical address	<input type="text"/>				
	<input type="text"/>				Postal code <input type="text"/>
Postal address	<input type="text"/>				
	<input type="text"/>				Postal code <input type="text"/>
Telephone number (h)	<input type="text"/>	Telephone number (w)	<input type="text"/>		
Cell phone number	<input type="text"/>				
Email address	<input type="text"/>				

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.

Please note: It is compulsory to provide contact details for any dependants who are of consenting age, as the Scheme will communicate directly with them, as required by law.

Please inform us of any changes to your contact details, so that the Scheme can communicate important information relating to your membership, benefits, rule changes or contribution increases, etc.

YOUR OPTION SELECTION FOR 2023

Please tick the option you prefer - only one may be selected. It is important to select the correct benefit option. Please ensure that you and your dependants understand the differences between the options. Study the member guide with particular reference to limits pertaining to those benefits that may affect you and your dependants. Benefits can be viewed on the website at www.mhcmf.co.za.

Please note: You need to 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

ESSENTIAL INCOME BANDS			
R0 - R3 275	R3 276 - R7 030	R7 031 - R10 305	R10 306+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick your income band and attach a copy of your payslip/proof of income.

CUSTOM

CUSTOM INCOME BANDS				
R0 - R3 490	R3 491 - R6 290	R6 291 - R9 195	R9 196 - R11 360	R11 361+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick your income band and attach a copy of your payslip/proof of income.

CLASSIC

HOSPICARE

OPTIMUM

CLASSIC NETWORK

HOSPICARE NETWORK

DISCLOSURE OF PERSONAL INFORMATION

The privacy and security of your personal information (which includes the personal information of your dependants) are important to Moto Health Care ('the Scheme'). The Scheme will only process personal information, which includes collecting, using, storing and sharing such information, in accordance with its [Privacy Policy](#) and if the processing is permitted by law, for a legitimate interest or otherwise with your consent. The Scheme will share your personal information with its agents (such as its Administrator and managed healthcare organisations) who assist it to administer your membership and provide you and your dependants with membership benefits.

The Scheme and its duly authorised service providers may only provide personal and clinical information with written consent from the member. It is a contravention of the Protection of Personal Information Act 4 of 2013 (POPIA) to do so without the consent of the person(s) whose information is being requested.

Please note that the Scheme will only provide information to another party where written consent has been received. The member consent form is available on our website at www.mhcmf.co.za. Consent may be withdrawn in writing at any time.

SIGNATURES

I, the undersigned, hereby confirm that the details provided in this application is true and correct.

Signature of principal member	<input type="text"/>	Date	<input type="text"/>
			DD/MM/YYYY

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

Please note: Your employer must approve and sign this form, unless you are a continuation member.

I/We warrant that the principal member referred to in this application is an employee of our organisation.

Signed on behalf of the employer	<input type="text"/>	Date	<input type="text"/>
			DD/MM/YYYY
Name of authorised signatory	<input type="text"/>		
Designation	<input type="text"/>		