APPLICATION FOR **EX GRATIA ASSISTANCE**

moto HEALTH CARE
taking care of our own

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

Please note: The Scheme reserves the right to request additional information if required. All personal information recorded on this form and submitted to us, shall be processed by Moto Health Care in accordance with the law and the Scheme's Privacy Policy, which is available on the website (www.mhcmf.co.za), or on request from our call centre (0861 000 300).

Important notes:

- An ex gratia application does not guarantee payment of the benefits being applied for. Before applying to the Scheme for ex gratia assistance, please ensure that you make alternate arrangements for the funding of such claims directly with the healthcare service provider.
- Ex gratia approvals may be granted by the review committee in its absolute discretion, provided it is satisfied that significant financial hardship or exceptional medical circumstances exist.
- **The following requirements are mandatory:**
- All sections of this form must be completed to prevent delays in processing your application.
  - A copy of your latest payslip is required.
  - Pensioners should include copies of their income advices/tax return.

REASONS AND MOTIVATION FOR EX GRATIA ASSISTANCE

Basis for this request (please tick): ☐ Financial hardship ☐ Exceptional circumstances ☐ Both

Please provide a short summary of your request, and attach supporting documentation and copies of claims, where necessary.

PRINCIPAL MEMBER DETAILS

Membership number		Join date of Moto Health Care	DD/MM/YYYY
Benefit option		Join date of option	DD/MM/YYYY
Identity/Passport number		Country of issue	
Title	Initials		
First names			
Surname			
Postal address			
		Postal code	
Contact telephone number			
Email address			
Number of dependants			
Ages of dependants			

CLINICAL REPORT

This section must be completed by the treating medical practitioner.

Diagnoses and ICD-10 code(s)

Medical history

Treatment plan and medication required

Medical practitioner's assessment of why this member's case warrants ex gratia assistance

Treating medical practitioner's name			
Practice number		Speciality	
Contact telephone number			
Treating medical practitioner's signature		Date	DD/MM/YYYY

FINANCIAL INFORMATION

This section must be completed by the principal member. If there are other occupants who contribute to your household income, please specify.

HOUSEHOLD INCOME	Principal member	Spouse/Partner	Other
Gross salary	R	R	R
Gross pension	R	R	R
Other income	R	R	R
Total gross income	R	R	R
Total deductions (e.g. UIF, PAYE etc.)	R	R	R
TOTAL HOUSEHOLD NET INCOME **(Total gross income less Total deductions)**	**R**	**R**	**R**

HOUSEHOLD EXPENSES

Please provide details of your household expenses, including that of the main member, spouse/partner or other occupants. If there are other occupants who contribute to your household expenses, please specify. If you already have a documented household budget, you may include it in support of this application.

Monthly expenses	Principal member	Spouse/Partner	Other
Bond (home loan)	R	R	R
Rent	R	R	R
Municipal rates and taxes	R	R	R
Water and electricity	R	R	R
Telephone/Cell phone	R	R	R
Internet service provider	R	R	R
Medical scheme contribution	R	R	R
Education fees (school, tertiary, university)	R	R	R
Vehicle repayments	R	R	R
Household insurances	R	R	R
Car insurances	R	R	R
Funeral cover	R	R	R
Life insurance	R	R	R
Transport and petrol	R	R	R
Groceries	R	R	R
Domestic and garden help	R	R	R
Clothing	R	R	R
Other (please specify below):			
	R	R	R
	R	R	R
	R	R	R
	R	R	R
	R	R	R
TOTALS	**R**	**R**	**R**

FINANCIAL INFORMATION (CONTINUED)

STATEMENT OF ASSETS

Assets	Value
Residential property owned	R
Other properties*	R
Vehicles and furniture	R
Shares and investments	R
Cash in bank	R
Other significant assets	R
TOTALS	**R**

Liabilities	Value
Mortgage bonds	R
Bank overdraft	R
Debt/loans	R
Creditors	R
TOTALS	**R**

*Please provide details of your other properties, i.e. second home, vacation home or rental property.

FINANCIAL STANDING

Total household net income

R

Total expenditure

R

Total balance (Income less expenses)

R

MEMBER DECLARATION

I, the undersigned, 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.

I certify that the information provided in this application form is true and correct to the best of my knowledge and belief.

Signature of principal member

Date

DD/MM/YYYY

EMPLOYER/PENSION FUND ADMINISTRATOR DETAILS

This section must be completed by an authorised representative of your employer or pension fund administrator. Please provide a copy of your pension slip/tax return. Contact your pension fund administrator for this information.

Name of employer/pension fund administrator

We confirm that the applicant is employed by us and receives a gross salary/is a member of our pension fund and receives a pension of

R per month.

Length of service with employer years months.

I, the undersigned, warrant that the principal member referred to in this application is an employee of our organisation/member of our pension fund.

Name of authorised signatory

Designation

Signed on behalf of the employer/pension fund

Date

DD/MM/YYYY