DECLARATION OF **HEALTH**

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

moto HEALTH CARE
taking care of our own

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).

If you have chosen not to disclose the nature of any medical conditions on your membership application form due to confidentiality, you may wait until you have received your valid Moto Health Care membership number. On receipt of your membership number, you may contact the call centre on 0861 000 300 to notify us whether you or your dependants have any medical conditions. **You are therefore required to complete and return this Declaration of Health form 30 days after you have applied for membership of Moto Health Care.**

Important notes:

- Please ensure that your membership on your previous medical scheme is cancelled once you have received notification of acceptance from Moto Health Care (if applicable).
- Please use this form to disclose whether you or any of your dependants have sought or received medical advice or treatment for any medical condition or illness, had any symptoms or received treatment for an illness that has not yet been diagnosed since the date of your application to Moto Health Care.
- Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

MEMBERSHIP DETAILS

Membership number			
Benefit option			
Start date of membership		**01**/MM/YYYY	
Full name and surname			
Identity/Passport number		Country of issue	
Contact telephone number			
Email address			

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY)

Should you or your beneficiaries fail to disclose any pre-existing medical conditions, certain benefits may be limited and/or excluded, it may result in a non-disclosure investigation, or your membership of the Scheme may be terminated.

Please answer 'Yes' or 'No' to each of these questions for you and your dependants. Please tick the appropriate box.

If you answer **'Yes'** to any of these questions, please provide detailed information of the medical conditions and treatment received in the last 12 months, or planned for the coming 12 months, for you and your dependants in the tables provided.

Please note: If additional space is required, please provide the details on a separate sheet of paper and attach it to the application.

1. **Are you or any of your dependants on chronic medication?** Yes ☐ No ☐

2. **Conditions related to the heart or cardiovascular system?** Yes ☐ No ☐
   Examples: heart murmur, high blood pressure (hypertension), high cholesterol (hypercholesterolaemia), shortness of breath, palpitations, chest pains, angina, heart attack and/or any other cardiac or blood condition.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

Medical history questions continued on page 2

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

3. **Respiratory or conditions relating to the lungs?** Yes ☐ No ☐
Examples: tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis (hay fever).

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

4. **Gynaecological conditions?** Yes ☐ No ☐
Examples: abnormal Pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, conditions of the cervix, menstrual disorders or any abnormality of pregnancy or confinement.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

5. **Currently pregnant or suspected pregnancy?** Yes ☐ No ☐

Full name and surname	Date of last menstrual cycle (DD/MM/YYYY)	How many weeks pregnant?	Expected delivery date (DD/MM/YYYY)	Name of treating doctor	Treating doctor's contact details

6. **Any conditions related to the digestive system, stomach, gall bladder, pancreas or liver?** Yes ☐ No ☐
Also indicate whether you or any of your dependants have had a gastroscopy or colonoscopy.
Examples: gastric or duodenal ulcer, heartburn, hiatus, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome (IBS), hepatitis cirrhosis or liver failure.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

Medical history questions continued on page 3

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

7. **Any conditions related to the kidneys, bladder or reproductive organs?** Yes ☐ No ☐
Examples: abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted infections or diseases.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

8. **Any conditions related to the central nervous system or brain? Also indicate whether you or any of your dependants have been advised to have or have had an MRI or CT scan.** Yes ☐ No ☐
Examples: epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis or Parkinson's disease.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

9. **Any mental health conditions?** Yes ☐ No ☐
Examples: depression, anxiety, panic attacks, schizophrenia, eating disorders, attention deficit hyperactivity disorder (ADHD) or post-traumatic stress disorder (PTSD).

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

10. **Any conditions related to the ears, nose, throat or eyes?** Yes ☐ No ☐
Examples: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, any autoimmune conditions, cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment or any congenital conditions.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

Medical history questions continued on page 4

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

11. **Any conditions relating to the skin, muscles, bones, joints, limbs or spine?** Yes ☐ No ☐
Examples: skin rash, arthritis, gout, fibromyalgia, back/neck/hip/knee or other joint trouble, multiple sclerosis, joint replacements, acne, eczema or psoriasis.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

12. **Any metabolic or endocrine conditions?** Yes ☐ No ☐
Examples: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, Conn's syndrome or any auto-immune or congenital conditions.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

13. **Removal of any cancer, growth or tumour, including moles?** Yes ☐ No ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

14. **Any specialised dental/maxillofacial treatment?** Yes ☐ No ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

Medical history questions continued on page 5

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) (CONTINUED)

15. **Any injuries or accidents, including motor vehicle accidents?** Yes ☐ No ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

16. **Any surgical procedures?** Yes ☐ No ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

17. **Any admissions to hospital or other medical facility?** Yes ☐ ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

18. **Taking any other medication for any condition not listed above?** Yes ☐ No ☐
Examples: homeopathic or other over-the-counter medication or multivitamins.

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

Medical history questions continued on page 6

MEDICAL HISTORY QUESTIONS (SPECIFIC WAITING PERIODS AND EXCLUSIONS MAY APPLY) CONTINUED

19. **Any other conditions or symptoms, not listed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could result in a medical claim within the next 12 months?** Yes ☐ No ☐

Full name and surname	Name of condition	Date of first diagnosis (DD/MM/YYYY)	Date of last occurence or related medical event (DD/MM/YYYY)	Treatment and medication recommended	Name of treating doctor	Treating doctor's contact details

HIV/AIDS

Should you or any of your dependants be HIV positive, you do not have to disclose your status on this application form. Please note, however, that **you must disclose your status to our HIV/AIDS Department within seven working days of submitting your membership application to Moto Health Care. Your information will be treated as strictly confidential.** This will allow for registration on our HIV **YourLife** Programme. You may receive a second membership card from the Scheme, subject to underwriting as per current legislation. A 12-month condition-specific waiting period may therefore apply.

HIV YourLife Programme contact details:
Telephone: 0860 109 793
Email address: ha@mhcmf.co.za

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 my Scheme membership and that of my dependants .

I declare 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

06/2023