EMPLOYER GROUP CONSENT FORM

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

moto HEALTH CARE
taking care of our own

AUTHORISATION FOR MOTO HEALTH CARE AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

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).

Please complete this form to grant consent to Moto Health Care and its Administrator to disclose your company information, including health information, and that of your employees, to appointed third party/ies. This consent excludes any identifiable personal information of your employees that may be disclosed in terms of the Protection of Personal Information Act 4 of 2013 (POPIA).

EMPLOYER INFORMATION

Name of employer group	
Employer group number	
Contact person	
Designation	
Contact telephone number	
Email address	

DETAILS OF FINANCIAL ADVISOR/BROKER

Broker name	
Broker number	
Brokerage name	
Brokerage number	

Signature of financial advisor/broker

Date
DD/MM/YYYY

Disclaimer: The Scheme will only pay the agreed commission to the Scheme's accredited brokerages. The Scheme has an agreement with certain brokerages and not with individual brokers. Commission is therefore paid to the accredited brokerage for the servicing of members.

TO WHOM OUR COMPANY INFORMATION MAY BE DISCLOSED

- **Healthcare service providers** ☐
- **Brokers/financial advisors** ☐
- **Other** ☐

Please specify the details of the appointed party/ies to whom your company information may be disclosed.

Identity/Passport number		Relationship	
Full name and surname			

To whom our company information be be disclosed continued on page 2

TO WHOM OUR COMPANY INFORMATION MAY BE DISCLOSED (CONTINUED)

Identity/Passport number		Relationship	
Full name and surname			
Identity/Passport number		Relationship	
Full name and surname			

WHAT COMPANY INFORMATION MAY BE DISCLOSED

Please indicate what company information may be disclosed to the appointed party/ies referred to above. Please note that only information relating to the categories below will be disclosed. **Please note that any company information disclosed will not include any personal information of your employee members and their dependants, but will be shared as de-identified or anonymous data.**

Scheme benefits and limits of our employee members ☐

Financial (e.g. Scheme contributions made on behalf of our employee members) ☐

Medical information of our employee members ☐

All of the above ☐

Time period from which this consent will be valid: _____ to _____.
DD/MM/YYYY DD/MM/YYYY

Please note: If a time period is not specified, the consent will operate from the date of the signature below and will continue thereafter indefinitely unless expressly withdrawn in writing by the employer group.

EMPLOYER CONSENT

Privacy, processing of personal information and consent

1. We have read the Privacy Policy of Moto Health Care and we fully understand how the Scheme will process our employees' personal information, with whom it will be shared and their rights in respect of such information.
2. We guarantee that, to the extent that it may be required by law, we have the necessary authority or permission from our employees to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by the Scheme, and should we not have such authority or permission, we indemnify the Scheme against any claim of whatsoever kind (including any action for damages) asserted or action taken against the Scheme by our employees and any of their dependants.
3. We authorise the Scheme to deal with us electronically and to treat electronic communication (such as email, online, fax, telephone, or communication through the Scheme's mobile app) as being the same as written authority and confirmation. We further agree that, where we choose to use electronic methods to transact with the Scheme, we will carry the risk of such use.
4. We consent to the recording of all conversations between ourselves and the Scheme or its authorised service providers, and all information obtained through these conversations will form part of the Scheme's records.
5. Should we have a complaint relating to the processing of our employees' personal information, we agree to first refer it to the Scheme to resolve in terms of their internal complaints process. The email address is complaints@mhcmf.co.za. If we are not satisfied with the outcome of the complaint, we understand that we may refer the complaint to the Information Regulator who can be contacted on 010 023 5200 or by email at enquiries@inforegulator.org.za.

EMPLOYER DECLARATION

We hereby:

- authorise Moto Health Care and its Administrator to disclose tour company information as defined above to the appointed party/ies;
- agree that neither Moto Health Care nor its Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure of any of our company information or that of our employee members pursuant to this consent;
- agree that once our consent is given, all our company information and that of our employee dependants as specified above, may be provided to the appointed party/ies;
- acknowledge that this consent will continue in force until expressly withdrawn by us in writing.

Employer declaration continued on page 3

EMPLOYER DECLARATION (CONTINUED)

We have carefully read this consent form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of our knowledge.

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

05/2023