

OPTION SELECTION FORM 2024



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 Sunday, 31 December 2023.**
- 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

Membership number	<input type="text"/>	Title	<input type="text"/>	Initials	<input type="text"/>
Full name and surname	<input type="text"/>				
Date of birth	<input type="text" value="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"/>		
Postal address	<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 referred method of communication

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.

Email
Post

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 2024

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. Please indicate your income band based on your gross monthly earnings (before deductions).

ESSENTIAL OPTION	<input type="checkbox"/>	<table border="1"> <thead> <tr> <th colspan="4">ESSENTIAL INCOME BANDS</th> </tr> </thead> <tbody> <tr> <td>R0 - R3 435</td> <td>R3 436 - R7 375</td> <td>R7 376 - R10 810</td> <td>R10 811+</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	ESSENTIAL INCOME BANDS				R0 - R3 435	R3 436 - R7 375	R7 376 - R10 810	R10 811+	<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.			
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CLASSIC OPTION	<input type="checkbox"/>	CLASSIC NETWORK OPTION	<input type="checkbox"/>															
HOSPICARE OPTION	<input type="checkbox"/>	HOSPICARE NETWORK OPTION	<input type="checkbox"/>	OPTIMUM OPTION <input type="checkbox"/>														

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" value="DD/MM/YYYY"/>
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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" value="DD/MM/YYYY"/>
Name of authorised signatory	<input type="text"/>		
Designation	<input type="text"/>		

10/2023