OPTION SELECTION FORM 2025

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

moto HEALTH CARE
taking care of our own

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 Tuesday, 31 December 2024.**
- 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		Title	Initials
Full name and surname			
Date of birth	DD/MM/YYYY	Gender Male ☐	Female ☐
Identity/Passport number		Country of issue	
Marital status		SARS income tax number	
Postal address			
		Postal code	
Telephone number (h)		Telephone number (w)	
Cell phone number			
Email address			

Please tick your preferred 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 2025

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 ☐

ESSENTIAL INCOME BANDS			
R0 - R3 618	R3 619 - R7 766	R7 767 - R11 383	R11 384+

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

CUSTOM OPTION ☐

CUSTOM INCOME BANDS					
R0 - R3 855	R3 856 - R6 950	R6 951 - R10 157	R10 158 - R12 547	R12 548 - R16 955	R16 956+

CLASSIC OPTION ☐ **CLASSIC NETWORK OPTION** ☐

HOSPICARE OPTION ☐ **HOSPICARE NETWORK OPTION** ☐ **OPTIMUM OPTION** ☐

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		Date	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		Date	DD/MM/YYYY
Name of authorised signatory			
Designation			

10/2024