APPLICATION FOR **MEMBERSHIP**

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

moto HEALTH CARE
taking care of our own

PERSONAL PARTICULARS

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).

APPLICANT

Title | Initials | Gender Male ☐ Female ☐

First names

Surname

Identity/Passport number | Country of issue

Date of birth DD/MM/YYYY

SARS income tax number

Marital status: Single ☐ Married ☐ Common law ☐ Divorced ☐ Separated ☐ Widow/er ☐

Race*: Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

CONTACT DETAILS

Physical address

Postal code

Postal address

Postal code

Telephone number (h) | Telephone number (w)

Cell phone number

Email address

Please tick your preferred method of communication Email ☐ Post ☐

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.

SPOUSE/PARTNER

Note: A marriage certificate or affidavit confirming co-habitation or proof of customary union is required.

Title | Initials | Gender Male ☐ Female ☐

First names

Surname

Identity/Passport number | Country of issue

Date of birth DD/MM/YYYY

Race*: Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

Relationship

Telephone number (h) | Telephone number (w)

Cell phone number

Email address

* ***It is not mandatory for you to provide this information. The Scheme is required by the Council for Medical Schemes to collect this data for statistical purposes only.***

Personal particulars continued on page 2

PERSONAL PARTICULARS (CONTINUED)

Please attach a copy of each dependant's ID, passport or birth certificate if the dependant is a child. The Scheme may contact you should there be outstanding information or if further documentation is required. **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.

DEPENDANT 1

First names | Gender Male ☐ Female ☐

Surname | Relationship

Identity/Passport number | Contact telephone number

Date of birth (DD/MM/YYYY) | Country of issue

Race* Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

Email address

Physical address

Postal code

DEPENDANT 2

First names | Gender Male ☐ Female ☐

Surname | Relationship

Identity/Passport number | Contact telephone number

Date of birth (DD/MM/YYYY) | Country of issue

Race* Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

Email address

Physical address

Postal code

DEPENDANT 3

First names | Gender Male ☐ Female ☐

Surname | Relationship

Identity/Passport number | Contact telephone number

Date of birth (DD/MM/YYYY) | Country of issue

Race* Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

Email address

Physical address

Postal code

DEPENDANT 4

First names | Gender Male ☐ Female ☐

Surname | Relationship

Identity/Passport number | Contact telephone number

Date of birth (DD/MM/YYYY) | Country of issue

Race* Black/African ☐ White ☐ Coloured ☐ **I do not wish to disclose my race** ☐

Indian ☐ Asian ☐ Other ☐ If 'Other', please specify:

Email address

Physical address

Postal code

* ***It is not mandatory for you to provide this information. The Scheme is required by the Council for Medical Schemes to collect this data for statistical purposes only.***

OPTION SELECTION

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 may 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** ☐

BANKING DETAILS OF APPLICANT (ONLY IF MEMBER PAYS THE CONTRIBUTIONS)

***Important note: Your details will only be processed upon receipt of a valid copy of your identity document, together with a letter stamped by your bank validating your banking details; alternatively the bank will need to stamp this completed form.**

Please do not provide credit card details. Moto Health Care cannot process debit orders from your credit card.

Name of account holder	
Name of bank	
Account number	
Branch name	
Branch code	
Type of account	

Signature of account holder

Please use this account for claims refund — Yes ☐ No ☐

BANKING DETAILS OF APPLICANT (FOR CLAIMS REFUNDS, IF IT IS DIFFERENT TO THE BANKING DETAILS ABOVE)

This section must only be completed if claims refunds should be paid into an account different from the account above.

Please do not provide credit card details.

Name of account holder	
Name of bank	
Account number	
Branch name	
Branch code	
Type of account	

Signature of account holder

EMPLOYER INFORMATION

Name of employer		
Employer/Group number		
Employer telephone number		
Employer email address		
Applicant's employee number		
Applicant's occupation		
Date of permanent employment		
Date membership is to start		01/MM/YYYY
Gross monthly income	R	

It is hereby confirmed that the applicant is in our employ and commenced employment on the date indicated above.

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

PREVIOUS MEDICAL SCHEME INFORMATION OF PRINCIPAL MEMBER, SPOUSE AND DEPENDANTS

Please provide details in the table below of any previous medical scheme membership for the principal member, your spouse and all your dependants. **Please ensure that you include membership certificates** from all medical schemes you and your dependants have previously belonged to (membership cards are not accepted). This includes the principal member and all dependants who are to be registered on the Scheme.

This information is required to determine any late-joiner penalties and/or waiting periods that may apply.

It remains the principal member's responsibility to ensure that membership of their previous medical schemes has been terminated prior to joining the Scheme to ensure that there is no dual membership. **It is illegal to belong to more than one medical scheme at the same time.**

Have you and/or any of your dependants, as per this application, had continuous medical scheme cover in the last 24 months without a break in cover of 90 days or more at any time during that time? Yes ☐ No ☐

Have you and/or any of your dependants been without medical scheme cover for a continuous period of 90 days or more at any time during the last 24 months? Yes ☐ No ☐

Name of medical scheme	Membership number	Join date (DD/MM/YYYY)	Termination date (DD/MM/YYYY)	Name of employer	Reason for leaving

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.

If you would prefer not to disclose the nature of any medical conditions 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 in order to notify us that you or your dependants have a medical condition. You will be asked to complete and return a separate Declaration of Health form. This information will be kept confidential. The responsibility will rest with the principal member to keep his or her dependants informed that they need to contact Moto Health Care to disclose any medical condition they have and for which they are receiving treatment.

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

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

Medical history questions continued on page 6

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

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? Also indicate whether you or any of your dependants have had a gastroscopy or colonoscopy.** Yes ☐ No ☐
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

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

Medical history questions continued on page 7

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

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

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

Medical history questions continued on page 8

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

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

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 ☐ 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 9

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

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

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

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 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 **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.

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

DETAILS OF FINANCIAL ADVISOR/BROKER (WHERE APPLICABLE)

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.

TERMS AND CONDITIONS

Words used in this application have the meaning as defined in the Scheme rules, unless otherwise stated.

1. **Rules of the Scheme**
   The rules of the Scheme govern membership and applications for membership. Please familiarise yourself with these rules. They are available on the Scheme website at www.mhcmf.co.za, from the registered office of the Scheme or may be requested by post.

2. **Membership**

   2.1 The information provided herein is complete and true. Should you and your dependants be accepted as members of this Scheme, the answers herein provided will form the basis of such membership.

   2.2 The acceptance of this application as well as your continued membership or that of your dependants is further dependent on your and your dependants' submission to any examination by the Scheme's medical advisor as and when the Scheme requires.

   2.3 You must submit evidence of your own good health and that of your dependants to the Scheme.

   2.4 The Scheme and duly authorised service providers are hereby authorised to obtain from any person any necessary information which they in their sole and absolute discretion may require concerning:
   2.4.1 any claim or risk assessment in relation to this application;
   2.4.2 your and your dependants' medical scheme membership.

   2.5 Any person in possession of the above information or evidence is hereby authorised and directed to provide same to the Scheme and its duly authorised service providers on request.

   2.6 Any medical doctor or other provider who attended to you or your dependants in the past or who will attend to you or your dependants in future, is hereby authorised to provide the Scheme and its duly authorised service providers with such information it may require on request.

   2.7 If you and your dependants are accepted as members, the registered rules of the Scheme are binding on you and your dependants.

   2.8 You are required to provide one month's written notice to the Scheme should you wish to terminate your membership or that of your dependants.

3. **Waiting periods and penalties**
   Moto Health Care reserves the right to underwrite all applications in accordance with the Medical Schemes Act (Act 131 of 1988) and the Scheme rules that prevail at the time of the application. These include imposing a three-month general waiting period (all benefits) and/or a 12-month waiting period on pre-existing conditions, and late-joiner contribution penalties.

   In the event that you or your dependants produce evidence of creditable coverage after a late-joiner penalty has been imposed, Moto Health Care shall recalculate the penalty and apply such revised penalty from the time such evidence is provided.

4. **Contributions**
   It is the responsibility of the principal member to ensure that the Scheme receives the monthly contribution for themselves and their dependants.

   4.1 Non-receipt by the Scheme of one month's contribution will result in suspension of medical benefits to you and your dependants. Such suspension will last until all arrear contributions have been brought up to date.

   4.2 Non-receipt by the Scheme of two months' contributions will result in cancellation of your and your dependants' membership to the Scheme.

   4.3 If your employer is responsible to pay your medical scheme contributions, the employer is hereby authorised and instructed to:
   - deduct from your remuneration (and any other remuneration due to you) any amounts that you may owe to the Scheme from time to time; and
   - pay such amounts to the Scheme.

   4.4 Any person (for example, your employer), who holds funds for your benefit after you cease employment, is hereby authorised and instructed to pay and continue to pay the amounts referred to in clause 4.6 to the Scheme as and when it is due.

   4.5 All sums owing to the Scheme must be paid on demand. Failure to pay any debt due to the Scheme will result in the suspension or cancellation of your or your dependants' membership and/or handover to a third party for debt collection.

   4.6 Any legal costs that may be incurred by the Scheme due to the recovery of any amount which may be owed to the Scheme, are payable by the member.

   4.7 When a member terminates his or her membership with the Scheme, and there is a balance owing to the Scheme exceeding the annual savings limit (ASL), the balance owing to the Scheme, due to the Scheme advancing the ASL, must be refunded not later than four months after termination of membership. The Scheme reserves the right to debit the member's bank account should the amount owing not be paid after four months.

5. **Online access to medical information**
   Once you have received confirmation that your membership to the Scheme has been accepted, please visit the Scheme's website at www.mhcmf.co.za to set up your online member profile. Click on the 'Login' tab to get started, then choose 'Member Login', click on 'Register' and follow the prompts to complete your registration. This is for web registration to access your profile, which will have your claim statements, claims history, authorisations, etc.

   Moto Health Care will not, in any way, be responsible or liable for any claims of any nature whatsoever made by anyone (yourself excluded), which arise as a result of you failing to keep your password and username secure and confidential to yourself. You indemnify Moto Health Care against any such claims and understand that this service may not be available 24 hours a day.

Terms and conditions continued on page 11

TERMS AND CONDITIONS (CONTINUED)

6. **Pre-authorisation**
   Should you or any of your dependants require hospitalisation for a non-emergency event, you must obtain pre-authorisation from the Scheme at least 48 hours before the event. Failure to do so will result in a co-payment payable to the Scheme for any procedure undertaken.
7. **Disclosure of information**
   The Scheme and its duly authorised service providers will only share personal (including clinical) information of our members and their dependants with third parties in accordance with the law and the Scheme rules or, if appropriate, with consent from the member or relevant dependant. The member consent form is available on our website at www.mhcmf.co.za.
8. No benefit will be payable by the Scheme unless it is satisfied by the validity of a claim and it has received all information required.
9. You are required to obtain the necessary consent from any of your dependants to whom these conditions may apply and hereby indemnify the Scheme and/or its Administrator, Momentum Health, against any claim which may arise as a result of your failure to do so.
10. A member shall notify the Scheme within 30 days of any change of address. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member's neglect to comply with the requirements of this rule.

YOUR PERSONAL INFORMATION

Please read the information below and provide your acceptance by signing the declaration on page 12.

1. The privacy and security of your personal information (and that of your dependants) are important to Moto Health Care ('the Scheme'). Moto Health Care 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.

   Moto Health Care 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.
2. All information required on this form is mandatory. Should any information be incorrect or incomplete, your application for membership may not be approved, your membership may be terminated (subject to payment of a reasonable cancellation fee) or it may prevent Moto Health Care from providing you and your dependants with benefits and services, including payment of claims.

   Moto Health Care may require additional information about you and your dependants to assess your eligibility for Scheme membership, apply waiting periods and/or late joiner penalties, subject to the provisions of the Medical Schemes Act and the Scheme rules, and for Moto Health Care to exercise its rights and discharge its obligations in terms of the agreement reached with members.

Momentum Multiply (Pty) Limited
You may choose to make use of additional products available from Momentum Multiply. Momentum Multiply is not a medical scheme and is a separate entity to Moto Health Care. Momentum Multiply's products are not medical scheme benefits. You may be a member of Moto Health Care without taking any of the products offered by Momentum Multiply.

I hereby authorise and give consent to Moto Health Care and its Administrator to share my personal information* including health information** and that of my dependants, with Momentum Multiply. This personal information will be processed and/or used for further processing in order to administer the applicable products with Momentum Multiply.

I am aware that, should I **no longer** want to receive this correspondence, I can withdraw my consent in writing.

☐ Tick here if you **consent** to the sharing of information with Momentum Multiply.

* *Personal information includes full names and surname, identity/passport number, contact details, medical scheme details, medical scheme membership number and membership status and corresponding dates of membership, employer group where applicable, gender, marital status (of you and your dependants).*

** *Health information includes healthy heart score which includes BMI, heart rate, cholesterol and glucose levels (of you and your dependants).*

For direct marketing purposes

I, _____ (full name and surname of member), hereby give my consent to Moto Health Care's Administrator for me to receive direct marketing of complementary products and services by Momentum Group and its subsidiaries, to be marketed to me by means of unsolicited electronic communication.

☐ Tick here if you do **not** wish to receive any direct marketing.

DECLARATION BY THE APPLICANT

1. I had an adequate opportunity to read and understand the contents of this document and all my questions have been answered satisfactorily.
2. I am applying for membership of Moto Health Care and warrant that all the information supplied, statements made on this application form and any accompanying information, whether completed by me or on my behalf, are, to the best of my knowledge and belief, correct and complete in every respect. I will advise Moto Health Care as soon as any of the information changes.
3. I understand that acceptance of my membership by Moto Health Care is subject to the Scheme's rules and is conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of this application and the date of membership. I undertake to advise Moto Health Care immediately of any deterioration occurring.
4. I am familiar with the conditions and the benefits of the option selected, notwithstanding representation by any other party.

Declaration by the applicant continued on page 12

DECLARATION BY THE APPLICANT (CONTINUED)

5. I understand that the information supplied on this application form, together with the supporting information, forms the basis of my membership of Moto Health Care and that my membership is subject to the conditions, exclusions and limitations of benefits in accordance with the Medical Schemes Act and the rules of the Scheme. In particular, I understand the requirements and implications of this document and confirm that I have declared all medical conditions.
6. I have read the Privacy Policy of Moto Health Care and I fully understand how the Scheme will process our personal information, with whom it will be shared and our rights in respect of such information.
7. I guarantee that, to the extent that it may be required by law, I have the necessary authority or permission from my dependants 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 Moto Health Care, and should I not have such authority or permission, I indemnify the Scheme against any claim of whatsoever kind (including any action for damages) asserted or action taken against Moto Health Care by me or any of my dependants.
8. I acknowledge that me and/or my dependants are also aware and fully understand the abovementioned.
9. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past, who will attend to us in the future or may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to Moto Health Care, or its contracted service providers, on request, for any purpose directly related to our membership, or which is authorised in terms of the Medical Schemes Act, the Scheme rules or any other legislation, also after the death or termination of membership of any of us.
10. I authorise Moto Health Care to deal with my dependants and I electronically and treat electronic communication (such as email, online, telephone or communication via the Moto Health Care mobile app) as being the same as written authority and confirmation. I further agree that, where we choose to use electronic methods to transact with Moto Health Care, we will carry the risk of such use.
11. I consent to the recording of all conversations between me (and my dependants) and the Scheme or its authorised service providers, and all information obtained through these conversations will form part of the Scheme's records.
12. I acknowledge that my dependants over the age of 12 years are aware that information regarding their health may be submitted directly to Moto Health Care.
13. If I have a complaint relating to the processing of my personal information, I 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 I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator on 010 023 5200 or via email at enquiries@inforegulator.org.za.

Signed by me as the applicant, declaring that I have carefully read this application form and accepting the fact that my application does not necessarily mean that I will be accepted as a member of the Scheme.

Signature of applicant

Date DD/MM/YYYY

11/2024

APPLICATION CHECKLIST

Important: We are unable to process your application if it is incomplete, incorrect, or you have not attached the relevant documents. Please use the checklist below as a guideline to ensure that all the relevant documentation has been provided.

- ☐ Have you completed all the sections relevant to your application?
- ☐ Have you completed the medical history section?
- ☐ Have you given us the correct contact details?
- ☐ Do we have your banking details so that we may collect your contributions and pay your claim refunds? **(only applicable if you are paying your contributions)**
  ***Important note: Your details will only be processed upon receipt of a valid copy of your identity document, together with a letter stamped by your bank validating your banking details; alternatively the bank will need to stamp this completed form.**
- ☐ Have you signed and dated the form? **(unsigned forms will be returned to you for signature)**
- ☐ Has your employer information section been completed?

Have you given us a copy of the following documentation, where applicable?

- ☐ Identity documents/passports of principal member as well as dependants
- ☐ Birth certificates for minor children
- ☐ Proof of full-time student registration (for student dependants)
- ☐ Legal adoption forms (if children are adopted)
- ☐ Certificates of membership for previous medical schemes
- ☐ Marriage certificate
- ☐ Affidavit must be completed by the principal member (should any dependant's surname differ from principal member's surname)
- ☐ Proof of income required from parents and grandparents for the addition of a grandchild
- ☐ Stamped copy of bank statement or certified letter from your bank validating your banking details