# APPLICATION FOR ADDITION OF DEPENDANTS

moto HEALTH CARE
taking care of our own

Telephone: **0861 000 300** | Email: **membership@mhcmf.co.za**

## PRINCIPAL MEMBER DETAILS

**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).**

| | | | |
|---|---|---|---|
| Membership number | | Employee number | |
| Benefit option | | | |
| Identity/Passport number | | Country of issue | |
| Title | Initials | | |
| First names | | | |
| Surname | | | |
| Race | Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose my race ☐ | | |
| | Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: | | |
| Street address | | | |
| | Postal code | | |
| Telephone number (home) | | Telephone number (work) | |
| Cell phone number | | | |
| Preferred email address | | | |

**Please make sure you provide us with a valid email address as all correspondence and statements will be emailed to you.**

## ADDITION OF DEPENDANTS

*** If a dependant is <u>not</u> living with you, please provide their physical/street address.**

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.

### 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 | | | |
| Date of birth | DD/MM/YYYY | | |
| Identity/Passport number | | Country of issue | |
| Race | Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose my race ☐ | | |
| | Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: | | |
| Contact telephone number | | Relationship | |
| Street address* | | | |
| | Postal code | | |
| Preferred email address | | | |

**Addition of dependants continued on page 2**

## ADDITION OF DEPENDANTS (CONTINUED)

***If a dependant is not living with you, please provide their physical/street address.**

### DEPENDANT 1

Title | Initials | Gender Male | Female

First names

Surname

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

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

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

Contact telephone number | Relationship

Street address*

Postal code

Preferred email address

### DEPENDANT 2

Title | Initials | Gender Male | Female

First names

Surname

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

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

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

Contact telephone number | Relationship

Street address*

Postal code

Preferred email address

### DEPENDANT 3

Title | Initials | Gender Male | Female

First names

Surname

Date of birth DD/MM/YYYY

Identity/Passport number | Country of issue

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

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

Contact telephone number | Relationship

Street address*

Postal code

Preferred email address

**Please see previous medical scheme information of dependants on page 3**

## PREVIOUS MEDICAL SCHEME INFORMATION OF DEPENDANTS

Please provide details in the table below of any previous medical scheme membership for your dependants. **Please ensure that you include membership certificates** from all medical schemes your dependants have previously belonged to (membership cards are not accepted). This includes 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 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 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 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 their membership of the Scheme may be terminated.**

Please notify the Scheme if any of 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 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 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. **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 4**

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

2. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

3. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

4. **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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

5. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

6. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**Medical history questions continued on page 5**

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

7. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

8. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

9. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

10. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**Medical history questions continued on page 6**

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

11. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

12. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

13. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

14. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

15. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**Medical history questions continued on page 7**

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

16. **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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

17. **Are you or any of your dependants on chronic medication for conditions not listed above?** Yes ☐ No ☐
If **yes**, please supply details below:

| 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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

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 any of your dependants be HIV positive, you do not have to disclose their status on this application form. Please note, however, that **they must disclose their status to our HIV Department within seven working days of submitting this application to Moto Health Care. Their information will be treated as strictly confidential.** This will allow for registration on our YourLife Programme. The member 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**

**Please see terms and conditions on page 8**

## TERMS AND CONDITIONS

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

**The rules of the Scheme govern membership. Please familiarise yourself with these rules once your membership has been approved by Moto Health Care. The rules are available on the Scheme website at www.mhcmf.co.za or from the registered office of the Scheme.**

1. **Membership**

1.1 Should you and your dependants be accepted as members of this Scheme, the answers provided herein will form the basis of your membership.

1.2 Membership may be dependent on examination by the Scheme's medical advisor.

**1.3 The Scheme and its 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:**
**1.3.1 any assessment in relation to your or your dependants health status and/or health risk;**
**1.3.2 your and your dependants' previous medical scheme membership.**

**1.4 I consent to any person in possession of the above information or evidence being authorised and directed to provide the Scheme and its duly authorised service providers on request.**

**1.5 I consent to any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in future, is hereby authorised to provide the Scheme and its duly authorised service providers with such information it may require on request.**

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

1.7 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.

2. **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 on contributions**, subject to the provisions of the Medical Schemes Act (Act 131 of 1988) and the Scheme rules, and for Moto Health Care to exercise its rights and discharge its obligations in terms of the law and Scheme rules.

Once you and your dependants produce evidence of credible coverage by a recognised South African medical scheme after a late-joiner penalty has been imposed, Moto Health Care shall recalculate the penalty and apply such revised penalty from the time that such evidence is provided.

3. **Contributions**

It is the responsibility of the principal member to ensure that the Scheme receives their and their dependants' monthly contributions timeously.

3.1 Should the Scheme not receive your contributions in accordance with the Scheme rules, it may result in suspension of medical scheme benefits or cancellation of membership to you and your dependants.

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

**3.3 If your employer is responsible to pay your medical scheme contributions, you hereby authorise and instruct the employer to:**
- **deduct from your monthly remuneration (and any other remuneration due to you) any amounts you may owe to the Scheme from time to time; and**
- **pay such amounts to the Scheme.**

**3.4 You hereby authorise and instruct any person (for example, your employer) who holds funds for your benefit after you cease employment, to pay and continue to pay the amounts to the Scheme when it is due.**

3.5 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.

3.6 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.

3.7 When a member terminates their membership with the Scheme, and there is a balance owing to the Scheme exceeding the annual savings limit, the balance owing to the Scheme must be paid back to the Scheme not later than four months after termination of membership.

**Terms and conditions continued on page 9**

## TERMS AND CONDITIONS (CONTINUED)

4. **Online access to medical information**

   Once you have received confirmation that your membership of 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, 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.**

5. **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. If you or your dependants are unable to communicate at the time of admission, your family members or the hospital staff may contact the Scheme for pre-authorisation.

6. **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**.

7. 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.

8. You are required to obtain the necessary consent from any of your dependants and hereby indemnify the Scheme and/or its Administrator, Momentum Health (Pty) Ltd, against any claim which may arise as a result of your failure to do so.

9. A member shall notify the Scheme within 30 days of any change of their contact details. 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. 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.

**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, once I subscribe to Momentum Multiply.**

☐ 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 communication 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 **consent** to receive direct marketing.

**Please see declaration by the applicant on page 10**

## DECLARATION BY THE APPLICANT

1. My dependants and I have had adequate opportunity to read and understand the contents of this document and all our 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 the acceptance of my membership by Moto Health Care is subject to the Scheme's rules.

4. I am familiar with the conditions and the benefits of the option selected, notwithstanding representation by any other party.

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 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.

9. 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.

10. 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.

11. 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.

12. 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 principal member | | Date | DD/MM/YYYY |

## EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

To be signed by an employer representative if your employer pays your contribution.

- I/We warrant that the principal member referred to in this application is an employee of our organisation.
- Moto Health Care may bill us for the amount due for this applicant's membership.

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

12/2025

**Please see applicant checklist on page 11**

## 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