# APPLICATION FOR **CONTINUATION OF MEMBERSHIP**

moto HEALTH CARE
taking care of our own

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

- Application for continuation of membership shall be lodged with the Scheme within 30 days from the date of the change.
- After 30 days, an application for membership form must be completed in addition to this continuation form.

## 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**

Membership number

Title | Initials | Gender: Male ☐ Female ☐

First names

Surname

Date of birth (DD/MM/YYYY) | SARS income tax number

Identity/Passport number | Country of issue

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:

***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.***

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.

## REASON FOR CONTINUATION OF MEMBERSHIP

**Please tick the appropriate block to indicate the reason for your continuation of membership request.**

☐ **Retirement**
Please supply a copy of your identity document/passport as well as a letter from your employer confirming your retirement.

☐ **Retrenchment**
Please supply a copy of your identity document/passport as well as a letter from your employer confirming your retrenchment.

☐ **Death of principal member**
Please attach a copy of the death certificate or a letter confirming date of death by medical practitioner.

☐ **Disability/Ill health retirement/medically boarded**
Please supply a letter of clinical motivation from your treating doctor, confirmation from your pension fund, proof of social grant (South African Social Disability Grant) and/or a letter from your employer group's human resources or payroll department.

☐ **Maternity/temporary absence**
Please provide a copy of your identity document/passport and a letter from your employer group's human resources or payroll department confirming the leave of absence.

☐ **Other**
Please specify, and provide supporting documentation.

## 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 certified confirmation of account letter from your bank or from your banking app 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 ☐

Moto Health Care may debit the above account with the contribution amount due under the contract in accordance with the Moto Health Care debit order system. I/We agree to inform Moto Health Care in writing of any changes that take place. I/We authorise Moto Health Care to verify such account details with the financial institution. I/We accept that Moto Health Care may debit the account on a date other than the date specified.

## 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

## 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 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** ☐

## 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 can 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.

Terms and conditions continued on page 4

## TERMS AND CONDITIONS (CONTINUED)

5. **Online access to medical information**

   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.

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 Administrator 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 5.**

1. The privacy and security of your personal information (which includes the personal information 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.

## 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 continuation of 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.

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.

Declaration by the applicant continued on page 5

## DECLARATION BY THE APPLICANT (CONTINUED)

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, fax, telephone, or communication through Moto Health Care's 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 can be submitted 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 who can be contacted 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 continuation member of the Scheme.**

Signature of applicant

Date DD/MM/YYYY

10/2024