EMPLOYER APPLICATION FORM

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

taking care of our own

Words used in this application have the same meaning as defined in the Scheme rules, unless otherwise stated. The employer is the agent of the member/employee and not of Moto Health Care in dealings between a member/employee and the Scheme.

Important notes:

- Kindly ensure that all details about the employer are fully disclosed. Every question must be completed by the employer and, if the question is not applicable, please insert N/A.
- Please do not resign from your current medical scheme until you have received written notification of acceptance from Moto Health Care. Each principal member must have started employment by the date that the employer joins Moto Health Care, in order to qualify for membership.
- Incomplete forms will result in membership being delayed.
- Changes to option selections may only be made annually with effect from 1 January each year.
- A copy of the Scheme rules is available on request.

EMPLOYER INFORMATION

Registration date DD/MM/YYYY

Full registered name

Registration number

If the above is not applicable, please state if partnership/sole proprietor or other:

Trading name

Type of business

Physical address

Postal code

Postal address

Postal code

Contact person

Designation

Telephone number (w) Cell phone number

Email address

EMPLOYER'S CURRENT AND PREVIOUS MEDICAL SCHEME INFORMATION

Has the employer previously been a group of Moto Health Care? Yes ☐ No ☐

If your answer is **'Yes'**, please state previous group number

Name of current medical scheme

Date joined DD/MM/YYYY

Date to be terminated DD/MM/YYYY

Name of current medical scheme

Date joined DD/MM/YYYY

Date to be terminated DD/MM/YYYY

Details of your employee base

Number of staff that your company employs

Number of principal members that Moto Health Care will cover

Employer's current and previous medical scheme information continued on page 2

EMPLOYER'S CURRENT AND PREVIOUS MEDICAL SCHEME INFORMATION (CONTINUED)

Details of your employee base (continued)

Will Moto Health Care be compulsory for all employees with a specific group? Yes ☐ No ☐

Will Moto Health Care be compulsory for all future employees? Yes ☐ No ☐

Will you offer any other medical scheme to employees? Yes ☐ No ☐

If **'Yes'**, please name the medical scheme

OPTION SELECTION (WHERE APPLICABLE, PLEASE TICK EMPLOYER'S PREFERENCE)

ESSENTIAL OPTION ☐

CLASSIC OPTION ☐

HOSPICARE OPTION ☐

OPTIMUM OPTION ☐

CUSTOM OPTION ☐

CLASSIC NETWORK OPTION ☐

HOSPICARE NETWORK OPTION ☐

COMMENCEMENT DATE

This employer's medical scheme contract shall commence on the **first day** of MM/YYYY

All eligible employees shall apply for membership of Moto Health Care with effect from the commencement date and, where such employees are accepted as members, their commencement date will be the same.

EMPLOYER PAYMENT DETAILS

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

Payment method: Electronic funds transfer (EFT) ☐ Debit order ☐ Other ☐

If **'Other'**, please specify:

Email address

Name of account holder

Name of bank

Account number

Branch name

Branch code

Type of account

We authorise Moto Health Care to verify such bank details with our bank.

Full name of authorised representative

Designation

Full name of authorised representative

Designation

Signed on behalf of the employer

Date DD/MM/YYYY

Name of authorised signatory

Designation

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

1. The person signing the contract on behalf of, or as the employer, acknowledges that he has been given a set of rules.
2. Failure to draw the employer's attention to any rule shall not in any way be regarded as excusing the employer from their obligation to thoroughly acquaint themselves with the rules.
3. If required by Moto Health Care, the employer shall make payment of contributions and other amounts due to Moto Health Care by automated clearing bureau (ACB), stop order or any form of electronic bank transfer (EFT), which Moto Health Care may reasonably require.
4. Moto Health Care is not obliged to pay any benefits where the member is in breach of any of the member's obligations in terms of the rules and in particular where any contribution or part thereof is in arrears.
5. The employer is the agent of the member and not of Moto Health Care in dealings between an employee and Moto Health Care.
6. The employer must notify Moto Health Care within 30 days of any change of address, and failure to notify will absolve Moto Health Care from any liability should the employer or member's rights be prejudiced or forfeited.

EMPLOYER DECLARATION

Membership

1. We hereby apply for membership of Moto Health Care and warrant that all the information supplied, statements made on this application form and any accompanying information are, to the best of our knowledge and belief, correct and complete in every respect. We will advise the Scheme as soon as any of this information changes.
2. We understand that acceptance of our employees' membership by the Scheme is subject to its rules. We agree that the rules of the Scheme, as amended from time to time, shall be binding on us. We undertake to observe and carry out (insofar as is applicable to us), our obligations in terms of the agreement with the Scheme.
3. We acknowledge that the Scheme does not accept liability for any employee until a notice of acceptance is given by the Scheme. We undertake to notify the Scheme immediately if any changes, which affect the answers to the application, occur before the Scheme grants written acceptance. This will enable the Scheme to reconsider the terms of acceptance.
4. We are familiar with the conditions and the benefits of the benefit option(s) selected, notwithstanding representation by any other party. We agree to participate in the benefit options as per the rules and terms and conditions of the Scheme.
5. We understand that the information supplied on this application form, together with the supporting information, forms the basis of our employees' membership of the Scheme and that their membership is subject to the conditions, exclusions and limitations of benefits in accordance with the Medical Schemes Act, No. 131 of 1998 and the rules of the Scheme.
6. Where the employer's membership of the Scheme is terminated, the employer shall ensure that the membership of all pensioners for whom the employer pays contributions to the Scheme is also terminated, notwithstanding that such pensioners are no longer employees of the employer and will be responsible for any loss or damage (particularly any underwriting loss), which the Scheme may suffer as a result of such pensioners continuing as members of the Scheme.
7. We shall give the Scheme one month's written notice of our intention to withdraw our membership from the Scheme.
8. Should we have any complaint relating to our membership, we 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.

Employer declaration continued on page 4

EMPLOYER DECLARATION (CONTINUED)

Privacy, processing of personal information and consent

1. We have read the Privacy Policy of Moto Health Care and we fully understand how the Scheme will process our employees' personal information, with whom it will be shared and their rights in respect of such information.
2. We guarantee that, to the extent that it may be required by law, we have the necessary authority or permission from our employees 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 the Scheme, and should we not have such authority or permission, we indemnify the Scheme against any claim of whatsoever kind (including any action for damages) asserted or action taken against the Scheme by our employees and any of their dependants.
3. We authorise the Scheme to deal with us electronically and to treat electronic communication (such as email, online, fax, telephone, or communication through the Scheme's mobile app) as being the same as written authority and confirmation. We further agree that, where we choose to use electronic methods to transact with the Scheme, we will carry the risk of such use.
4. We consent to the recording of all conversations between ourselves and the Scheme or its authorised service providers, and all information obtained through these conversations will form part of the Scheme's records.
5. Should we have a complaint relating to the processing of our employees' personal information, we 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 we are not satisfied with the outcome of the complaint, we understand that we may refer the complaint to the Information Regulator who can be contacted on 010 023 5200 or by email at enquiries@inforegulator.org.za.

Contributions

1. We agree that contributions will be paid monthly and will be submitted to reach Moto Health Care by no later than the third day of the month for which the amounts are due.
2. We accept that if contributions are not paid by its due date for a member, the Scheme will suspend benefits with immediate effect. If the contributions are not paid within 30 days from the suspension date, that employee's membership will be terminated.
3. The employer warrants that there is an arrangement in place with every Scheme member of the employer, that amounts due to the Scheme shall be recouped by the employer from such member's income.
4. The employer shall deduct all amounts due to the Scheme from the remuneration due to the employee and shall be responsible for ensuring that the same is done in compliance with the law. Likewise, the employer shall be responsible for arranging with the employer's pension and other schemes that all sums due to the Scheme by the employee upon the employee's ceasing to be employed shall be paid by such pension or other scheme, directly to the Scheme, particularly where the employee continues as a member of the Scheme after ceasing to be employed by the employer. As and when the employee ceases to be a member of the Scheme, the employer shall pay to the Scheme all amounts due by the employee to the Scheme including but not necessarily limited to contributions, amounts paid to providers and amounts lent and advanced by the Scheme to the employee to assist the employee in paying for relevant health services.

We agree that no statements, promises or information made or given to us by any other persons shall be binding on the Scheme or affect its rights in any way whatsoever, unless such statements, promises and information is incorporated in writing and accepted by the Scheme.

We declare and warrant that the answers to the foregoing questions are complete and true, and agree that this application shall form the basis of the agreement with the Scheme and that, if any statements are untrue, membership may be terminated, all benefits reversed and contributions shall be forfeited.

We understand the requirements and implications of this document, and that this contract will not bind the Scheme until written acceptance is received from the Scheme.

We have carefully read this application form and accept the fact that this application does not necessarily mean that we will be accepted as employee members of the Scheme.

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

10/2024