EMPLOYER APPLICATION FORM

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

moto HEALTH CARE
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.
- Incomplete forms will result in delays.
- 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

Street address

Postal code

Contact person

Designation

Telephone number (work) Cell phone number

Preferred 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

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

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 fund transfer (EFT).
4. Should contributions not be paid timeously, Moto Health Care will suspend members.
5. The employer has informed the member that they are acting as an agent between Moto Health Care and employees.
6. The employer must notify Moto Health Care within 30 days of their change of contact details.

EMPLOYER DECLARATION

Membership

1. We hereby warrant that all the information supplied and statements made on this application form are correct and complete. We will advise the Scheme as soon as any of this information changes.
2. We agree that the rules of the Scheme, as amended from time to time, shall be binding on us.
3. We undertake to notify the Scheme immediately if any changes, which affect the answers to the application, occur before the Scheme grants written acceptance.
4. We are familiar with the conditions and the benefits of the benefit option(s), notwithstanding representation by any other party.
5. We shall give the Scheme one month's written notice of our intention to withdraw from the Scheme.
6. 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**.

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 data and 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 from our employees to provide the 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, 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, 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 to employee members 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, which amounts due to the Scheme shall be recouped by the employer from such member's salary.
4. The employer shall deduct all amounts due to the Scheme from the remuneration due to the employee by the employer and shall be responsible for ensuring that the same is done in compliance with the law.

We agree that no statements, promises or information made or given to the employer and/or broker 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 herein 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.

Employer declaration continued on page 4

EMPLOYER DECLARATION (CONTINUED)

We understand 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			

12/2025