MEMBERSHIP **RECORD AMENDMENT**

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

moto HEALTH CARE
taking care of our own

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).

Important notes:
Your employer must sign this form, unless you are an individual member.
A 30 days' notice period is required to terminate the membership of the principal member or any dependants.

PRINCIPAL MEMBER DETAILS

Membership number		Benefit option	
Identity/Passport number		Country of issue	
First names			
Surname			
Employee number			

REQUEST FOR (please tick relevant box)

- ☐ Change of contact details – **Section 1**
- ☐ Termination of dependant membership – **Section 2**
- ☐ Termination of principal membership – **Section 3**

SECTION 1: CHANGE OF CONTACT DETAILS

Physical address			
		Postal code	
Postal address			
		Postal code	
Telephone number (h)		Telephone number (w)	
Cell phone number			
Email address			
Effective date	01/MM/YYYY		

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.

SECTION 2: TERMINATION OF DEPENDANT MEMBERSHIP

Please provide the dependants' details for whom membership of Moto Health Care is being terminated.

DEPENDANT 1

Effective date	01/MM/YYYY	Gender Male ☐	Female ☐
First names			
Surname			
Date of birth	DD/MM/YYYY	Relationship	
Identity/Passport number		Country of issue	

Termination of dependant membership continued on page 2

SECTION 2: TERMINATION OF DEPENDANT MEMBERSHIP (CONTINUED)

DEPENDANT 1 (CONTINUED)

Reason for termination of membership

Self-supporting ☐ Marriage ☐ Divorce ☐ Overseas ☐ Other (please specify) ☐

Death (please supply death certificate) ☐ Transfer to a new medical scheme ☐

DEPENDANT 2

Effective date 01/MM/YYYY Gender Male ☐ Female ☐

First names

Surname

Date of birth DD/MM/YYYY Relationship

Identity/Passport number Country of issue

Reason for termination of membership

Self-supporting ☐ Marriage ☐ Divorce ☐ Overseas ☐ Other (please specify) ☐

Death (please supply death certificate or a letter confirming date of death by medical practitioner) ☐ Transfer to a new medical scheme ☐

SECTION 3: TERMINATION OF PRINCIPAL MEMBERSHIP

Effective date 01/MM/YYYY

Reason for termination

Marriage ☐
Divorced/Separated ☐
Dismissal ☐
Retrenchment ☐
Retirement ☐
Financial reasons ☐
Relocating overseas ☐

Change of employment ☐
Left Scheme due to DSP ☐
Left Scheme due to underwriting ☐
Left Scheme due to product ☐
Left Scheme due to service ☐
Left company (no longer employed) ☐

Death (please supply death certificate or a letter confirming date of death by medical practitioner) ☐

Transfer to new employer group ☐
(**Important:** please complete a Member change of employer form)

Transfer to a new medical scheme ☐
(A copy of your identity document/ passport document is required. **This is mandatory.**)

Please provide the details of the new medical scheme (this is required for transfer of positive savings balance, if applicable).

New medical scheme membership number

If your new medical scheme does not have a savings component or if you are not joining another medical scheme, please provide your banking details below. Should you have a positive medical savings account balance, Moto Health Care will pay it into your bank account. Please provide a stamped letter from your bank to confirm your bank account details. **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 Date DD/MM/YYYY

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN MEMBERSHIP

To be signed by an employer representative if the 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 update billing for this member in the same manner as for other Scheme members employed by our organisation.

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

MEMBER DECLARATION

I hereby authorise the Scheme and/or its duly authorised service providers to obtain from any person any necessary information, which relates to any aspect of my Scheme membership and that of my dependants.

I certify that the information provided in this application form is true and correct to the best of my knowledge and belief.

Signature of principal member		Date	DD/MM/YYYY

10/2024