MEMBERSHIP RECORD AMENDMENT

moto HEALTH CARE
taking care of our own

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

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

If any of your contact details have changed, please indicate them here.

Street address			
		Postal code	
Telephone number (home)		Telephone number (work)	
Cell phone number			
Preferred email address			
Effective date	01/MM/YYYY		

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

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	

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 ☐		

Termination of dependant membership continued on page 2

SECTION 2: TERMINATION OF DEPENDANT MEMBERSHIP (CONTINUED)

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	☐	Left Scheme due to underwriting	☐
Divorced/Separated	☐	Lef t Scheme due to product	☐
Dismissal	☐	Left Scheme due to service	☐
Retrenchment	☐	Left company	☐
Retirement	☐	Transfer to new employer group	☐
Financial reasons	☐	Transfer to a new medical scheme	☐
Relocating overseas	☐	Death (please supply death certificate or a letter confirming date of death by medical practitioner)	☐
Change of employment	☐		
Left Scheme due to DSP	☐		

Please provide the details of the new medical scheme (this is required for transfer of available positive savings balance after deductions of any outstanding debts to the Scheme, if applicable.

Medical scheme name

Medical scheme number | Benefit option

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 available positive savings balance after deductions of any outstanding debts to the Scheme, 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

Please see employer acknowledgement in change of membership on page 3

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.

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

MEMBER DECLARATION

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

12/2025