APPLICATION FOR CONTINUATION OF MEMBERSHIP

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

moto HEALTH CARE
taking care of our own

- 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						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:				

Street address			
		Postal code	
Telephone number (home)		Telephone number (work)	
Cell phone number			
Preferred email address			

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

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 800	R3 801 - R8 154	R8 155 - R11 952	R11 953+

Please tick your income band and attach a copy of your payslip/proof of income.

CUSTOM OPTION ☐

CUSTOM INCOME BANDS					
R0 - R4 047	R4 048 - R7 297	R7 298 - R10 664	R10 665 - R13 174	R13 175 - R17 802	R17 803+

CLASSIC OPTION ☐ **CLASSIC NETWORK OPTION** ☐

HOSPICARE OPTION ☐ **HOSPICARE NETWORK OPTION** ☐ **OPTIMUM OPTION** ☐

Please see terms and conditions on page 3

TERMS AND CONDITIONS

Words used in this application have the meaning as defined in the Scheme rules, unless otherwise stated.

The rules of the Scheme govern membership. Please familiarise yourself with these rules once your membership has been approved by Moto Health Care. The rules are available on the Scheme website at www.mhcmf.co.za or from the registered office of the Scheme.

1. **Membership**

1.1 Should you and your dependants be accepted as members of this Scheme, the answers provided herein will form the basis of your membership.

1.2 Membership may be dependent on examination by the Scheme's medical advisor.

1.3 The Scheme and its 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:
1.3.1 any assessment in relation to your or your dependants health status and/or health risk;
1.3.2 your and your dependants' previous medical scheme membership.

1.4 I consent to any person in possession of the above information or evidence being authorised and directed to provide the Scheme and its duly authorised service providers on request.

1.5 I consent to any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in future, is hereby authorised to provide the Scheme and its duly authorised service providers with such information it may require on request.

1.6 If you and your dependants are accepted as members, the registered rules of the Scheme are binding on you and your dependants.

1.7 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.

2. **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 on contributions**, subject to the provisions of the Medical Schemes Act (Act 131 of 1988) and the Scheme rules, and for Moto Health Care to exercise its rights and discharge its obligations in terms of the law and Scheme rules.

Once you and your dependants produce evidence of credible coverage by a recognised South African medical scheme after a late-joiner penalty has been imposed, Moto Health Care shall recalculate the penalty and apply such revised penalty from the time that such evidence is provided.

3. **Contributions**

It is the responsibility of the principal member to ensure that the Scheme receives their and their dependants' monthly contributions timeously.

3.1 Should the Scheme not receive your contributions in accordance with the Scheme rules, it may result in suspension of medical scheme benefits or cancellation of membership to you and your dependants.

3.2 Non-receipt by the Scheme of two months' contributions will result in cancellation of your and your dependants' membership to the Scheme.

3.3 If your employer is responsible to pay your medical scheme contributions, you hereby authorise and instruct the employer to:
- **deduct from your monthly remuneration (and any other remuneration due to you) any amounts you may owe to the Scheme from time to time; and**
- **pay such amounts to the Scheme.**

3.4 You hereby authorise and instruct any person (for example, your employer) who holds funds for your benefit after you cease employment, to pay and continue to pay the amounts to the Scheme when it is due.

3.5 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.

3.6 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.

3.7 When a member terminates their membership with the Scheme, and there is a balance owing to the Scheme exceeding the annual savings limit, the balance owing to the Scheme must be paid back to the Scheme not later than four months after termination of membership.

Terms and conditions continued on page 4

TERMS AND CONDITIONS (CONTINUED)

4. **Online access to medical information**

   Once you have received confirmation that your membership of the Scheme has been accepted, please 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, 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.**

5. **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. If you or your dependants are unable to communicate at the time of admission, your family members or the hospital staff may contact the Scheme for pre-authorisation.

6. **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**.

7. 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.

8. You are required to obtain the necessary consent from any of your dependants and hereby indemnify the Scheme and/or its Administrator, Momentum Health (Pty) Ltd, against any claim which may arise as a result of your failure to do so.

9. A member shall notify the Scheme within 30 days of any change of their contact details. 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 (and that of your dependants) are important to Moto Health Care. 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.

Momentum Multiply (Pty) Limited

You may choose to make use of additional products available from Momentum Multiply. Momentum Multiply is not a medical scheme and is a separate entity to Moto Health Care. Momentum Multiply's products are not medical scheme benefits. You may be a member of Moto Health Care without taking any of the products offered by Momentum Multiply.

I hereby authorise and give consent to Moto Health Care and its Administrator to share my personal information* including health information and that of my dependants, with Momentum Multiply, once I subscribe to Momentum Multiply.**

☐ Tick here if you **consent** to the sharing of information with Momentum Multiply.

* *Personal information includes full names and surname, identity/passport number, contact details, medical scheme details, medical scheme membership number and membership status and corresponding dates of membership, employer group where applicable, gender, marital status (of you and your dependants).*

** *Health information includes healthy heart score which includes BMI, heart rate, cholesterol and glucose levels (of you and your dependants).*

For direct marketing purposes

I, FULL NAME AND SURNAME OF MEMBER _____ , hereby give my consent to Moto Health Care's Administrator for me to receive direct marketing communication of complementary products and services by Momentum Group and its subsidiaries, to be marketed to me by means of unsolicited electronic communication.

☐ Tick here if you **consent** to receive direct marketing.

Please see declaration by the applicant on page 5

DECLARATION BY THE APPLICANT

1. My dependants and I have had adequate opportunity to read and understand the contents of this document and all our questions have been answered satisfactorily.

2. I am applying for 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 the acceptance of my membership by Moto Health Care is subject to the Scheme's rules.

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.

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 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.

9. I authorise Moto Health Care to deal with my dependants and I electronically and treat electronic communication (such as email, online, telephone or communication via the Moto Health Care 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.

10. 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.

11. I acknowledge that my dependants over the age of 12 years are aware that information regarding their health may be submitted directly to Moto Health Care.

12. 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 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

12/2025