INDIVIDUAL HEALTH ASSESSMENT CONSENT FORM

PO Box 2338, Durban 4000 | Telephone: **0861 000 300** | Email: **info@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:
Moto Health Care (MHC) members receive **one free health assessment** from the wellness programme benefit. This benefit is for members and/or dependants who are 21 years and older.

- **Please obtain pre-authorisation for this assessment through the self-service option by logging onto the Scheme's website at www.mhcmf.co.za. You may also contact the call centre on 0861 000 300 or email info@mhcmf.co.za.**
- This health assessment can be done at affiliated pharmacies. The results will be submitted directly to the Scheme. If this test was done at a general practitioner (GP), please note that the claim will be processed from your day-to-day or annual savings limit (ASL).
- **Custom and Essential Option members must have their health assessments done by a network provider.**
- For GP billing purposes, kindly use tariff code 969220. The health assessment tariff code is different to the consultation tariff code. For pharmacy billing purposes, please use NAPPI code 711326001.
- **This form must be completed in full and returned by email to info@mhcmf.co.za.**

MEMBERSHIP DETAILS

Membership number			
Benefit option		Dependant code	
Gender	Male ☐ Female ☐		
Full name and surname			
Date of birth	DD/MM/YYYY		
Identity/Passport number		Country of issue	
Contact telephone number			
Email address			

HEALTH INFORMATION

All fields listed below are compulsory:

Height			cm
Weight			kg
Waist circumference			cm
Cholesterol			mmol/L
Blood pressure	Systolic		mmHg
	Diastolic		mmHg
Pregnant*	Yes ☐ No ☐	Up to six months postpartum	☐
Smoker	Yes ☐ No ☐		

Please complete your height, weight and waist circumference even if you are pregnant.

DECLARATION BY THE ATTENDING HEALTHCARE PROFESSIONAL

I declare that I have conducted the tests and examination as set out in this form.

Full name and surname			
Practice number		Discipline/speciality	
Contact telephone number			
Email address			

Healthcare professional signature		Date	DD/MM/YYYY

MEMBER DECLARATION

I consent that my health information will be disclosed to the Scheme and its Administrator.

I understand that the Scheme and its Administrator will store the data on their database to assess my health risk, understand my health status and improve it. These entities will keep the results confidential and will not disclose results to third parties without my consent and will implement security measures against unauthorised processing of my personal and health information by any third party/ies.

Indemnity
I understand that the Scheme, its Trustees and its employees will not accept any responsibility and shall not be liable for any injury, death, illness, loss or other damages of any nature (direct or indirect, special or consequential) suffered or incurred during or resulting from my participation in the aforementioned tests and the use of the results thereof. I have read and understood the above consent, purpose and indemnity.

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

Signature of principal member/dependant		Date	DD/MM/YYYY

04/2025