NEWBORN REGISTRATION

PO Box 2338, Durban 4000 | Telephone: **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:

- Please register your newborn baby/ies as a dependant on Moto Health Care within 30 days of birth.
- The Application for Addition of Dependant form must be completed if you register your baby as a dependant after 30 days of their birth.
- Please attach a copy of the confirmation of live birth from the hospital, or the birth certificate, if available.

PRINCIPAL MEMBER DETAILS

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

Race*: Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose my race ☐
Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: ____

Physical address			
		Postal code	
Telephone number (home)		Telephone number (work)	
Cell phone number			
Email address			

NEWBORN DEPENDANT DETAILS

Full name and surname: ____
Date of birth: DD/MM/YYYY Gender: Male ☐ Female ☐
Race*: Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose ☐
Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: ____

Full name and surname: ____
Date of birth: DD/MM/YYYY Gender: Male ☐ Female ☐
Race*: Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose ☐
Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: ____

Full name and surname: ____
Date of birth: DD/MM/YYYY Gender: Male ☐ Female ☐
Race*: Black/African ☐ White ☐ Coloured ☐ I do not wish to disclose ☐
Indian ☐ Asian ☐ Other ☐ If 'Other', please specify: ____

* ***It is not mandatory for you to provide this information. The Scheme is required by the Council for Medical Schemes to collect this data for statistical purposes only.***

PARENTS' DETAILS

Mother's full name and surname	
Father's full name and surname	
Adoptive parent's full name and surname	
Adoptive parent's full name and surname	

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

To be signed by an employer representative if your 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 bill us for the amount due for this applicant's membership.

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

04/2025