

NEWBORN REGISTRATION



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:

- 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	<input type="text"/>	Benefit option	<input type="text"/>
Identity/Passport number	<input type="text"/>	Country of issue	<input type="text"/>
Title	<input type="text"/>	Initials	<input type="text"/>
First names	<input type="text"/>		
Surname	<input type="text"/>		
Race	Black/African <input type="checkbox"/> White <input type="checkbox"/> Coloured <input type="checkbox"/> I do not wish to disclose my race <input type="checkbox"/>		
	Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> If 'Other', please specify: <input type="text"/>		
Street address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Telephone number (home)	<input type="text"/>	Telephone number (work)	<input type="text"/>
Cell phone number	<input type="text"/>		
Preferred email address	<input type="text"/>		

NEWBORN DEPENDANT DETAILS

Full name and surname	<input type="text"/>		
Date of birth	<input type="text" value="DD/MM/YYYY"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Race	Black/African <input type="checkbox"/> White <input type="checkbox"/> Coloured <input type="checkbox"/> I do not wish to disclose <input type="checkbox"/>		
	Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> If 'Other', please specify: <input type="text"/>		
Full name and surname	<input type="text"/>		
Date of birth	<input type="text" value="DD/MM/YYYY"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Race	Black/African <input type="checkbox"/> White <input type="checkbox"/> Coloured <input type="checkbox"/> I do not wish to disclose <input type="checkbox"/>		
	Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> If 'Other', please specify: <input type="text"/>		
Full name and surname	<input type="text"/>		
Date of birth	<input type="text" value="DD/MM/YYYY"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Race	Black/African <input type="checkbox"/> White <input type="checkbox"/> Coloured <input type="checkbox"/> I do not wish to disclose <input type="checkbox"/>		
	Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> If 'Other', please specify: <input type="text"/>		

PARENTS' DETAILS

Mother's full name and surname	<input type="text"/>
Father's full name and surname	<input type="text"/>
Adoptive parent's full name and surname	<input type="text"/>
Adoptive parent's full name and surname	<input type="text"/>

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	<div></div>	Date	<div>DD/MM/YYYY</div>
Name of authorised signatory	<div></div>		
Designation	<div></div>		

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	<div></div>	Date	<div>DD/MM/YYYY</div>
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12/2025