MEMBER/DEPENDANT CONSENT FORM

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:

- To avoid delays in processing your application, please ensure that this form is completed in full.
- Return the completed and signed form by email to **membership@mhcmf.co.za**.
- Please attach a copy of the principal member's identity document, as well as the identity documents of all consenting parties.
- If you need assistance in completing this form, please call **0861 000 300**.

SCHEME MEMBERSHIP INFORMATION

Membership number	
Benefit option	

PARTICULARS OF PERSON/ENTITY GIVING CONSENT

Principal member, registered dependant(s) or appointed third party/ies

Full name and surname			
ID number		Dependant code*	
Name of registered entity (if applicable)			
Designation/capacity of authorised representative named above			
Contact telephone number			
Street address			
		Postal code	
Preferred email address			

* ***Dependant code of principal member or registered dependants, if applicable***

TO WHOM YOUR INFORMATION MAY BE DISCLOSED

Please specify the details of the appointed party/ies to whom your information may be disclosed.

THIRD PARTY 1

Once-off consent ☐ Yes ☐ No Continuous consent ☐ Yes ☐ No

Time period for which consent will be valid: DD/MM/YYYY to DD/MM/YYYY

Please note: If period is not specified, the consent will operate from the date of the signature below and will continue thereafter indefinitely unless expressly withdrawn in writing by the applicant.

Relationship to principal member/registered dependant	
Full name and surname	
ID number	
Date of birth	DD/MM/YYYY

TO WHOM YOUR INFORMATION MAY BE DISCLOSED (CONTINUED)

THIRD PARTY 1 (CONTINUED)

Name of registered entity (if applicable)

Occupation/designation

Contact telephone number

Street address

Postal code

Preferred email address

THIRD PARTY 2

Once-off consent ☐ Yes ☐ No Continuous consent ☐ Yes ☐ No

Time period for which consent will be valid: DD/MM/YYYY to DD/MM/YYYY

Please note: If period is not specified, the consent will operate from the date of the signature below and will continue thereafter indefinitely unless expressly withdrawn in writing by the applicant.

Relationship to principal member/registered dependant

Full name and surname

ID number

Date of birth DD/MM/YYYY

Name of registered entity (if applicable)

Occupation/designation

Contact telephone number

Street address

Postal code

Preferred email address

INFORMATION THAT MAY BE DISCLOSED

Please indicate what information may be disclosed to the appointed party/ies referred to above. Please note that only information relating to the categories you select below will be disclosed.

TYPE OF INFORMATION

THIRD PARTY 1	THIRD PARTY 2	
☐	☐	**Personal information** *Personal details, such as your ID number, physical address and contact details, etc.*
☐	☐	**Scheme benefit information** *Benefits and limits, claims history, etc.*
☐	☐	**Financial information** *Banking details, claims, contributions and amounts due to the Scheme, etc.*
☐	☐	**Medical information** *Personal medical history, diagnoses, treatment plans, chronic information, hospitalisations and authorisations, etc.*
☐	☐	**Scheme membership documents** *Claims statements, membership and tax certificates, etc.*
☐	☐	**All of the above**

CONSENT

We request your consent to disclose your information to the appointed party/ies mentioned on pages 1 and 2 for the purposes set out below.

While your consent is voluntary, it is a requirement for Moto Health Care and its Administrator, Momentum Health (Pty) Ltd, a division of Momentum Group Limited, to keep your personal information confidential and to comply with the Protection of Personal Information Act 4 of 2013 (POPIA) when processing your information.

Members' and their registered dependants' information will be processed for the purposes as outlined in the Medical Schemes Act 131 of 1998.

Please read the statements below and sign your acceptance thereof in the **DECLARATION** on page 4.

1. I authorise, and give consent to the Scheme and its Administrator to collect, store, collate, process, share and further process my information, for purposes of Scheme membership risk profiling and management, administration of membership and as set out in this section.

2. If I have consented to the disclosure of my information, the Scheme or its Administrator may provide my information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between the Scheme or its Administrator, which requires them to do so.

3. I acknowledge that I must give the Scheme and its Administrator all information and evidence they may require from time to time.

   I authorise the Scheme and its Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to the principal member and their registered dependants in the past, or who will attend to them in the future, any information the Scheme may require concerning the principal member and their registered dependants in assessing any risk or claim in relation to this application, their membership of the Scheme and risk profiling or management.

   I consent to that person providing, and instruct that person to provide, the Scheme and its Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.

4. I have the right to withdraw my consent to have my information disclosed provided that the lawfulness of the processing of my information before my withdrawal will not be affected.

5. I have the right to object on reasonable grounds relating to my particular situation, to disclosing my information unless it is required by law.

6. I have the right to request my information, which is in the possession of the Scheme and its Administrator, provided that I furnish adequate identification.

7. I have the right to request the Scheme and its Administrator where necessary, to correct or delete my information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.

8. If I have a complaint relating to the processing of my information, I agree to first refer it to the Scheme's Administrator to resolve it in terms of their internal complaints process.

   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 by email at **enquiries@inforegulator.org.za**.

9. My information will be shared between the Scheme, its Administrator and any of their contracted third parties who require this information, for purposes related to membership of the Scheme.

DECLARATION

I, the undersigned, hereby:

- authorise Moto Health Care and its Administrator to disclose the above information to the appointed party/ties as indicated on pages 1 and 2
- agree that neither Moto Health Care nor its Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure of my information pursuant to this consent
- agree that once consent is provided, all my information as indicated herein may be disclosed to the appointed party/ies.

Declaration continued on page 4

DECLARATION (CONTINUED)

I declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of my knowledge.

Signature of person/entity/appointed third party giving consent

Date DD/MM/YYYY

03/2026