

2027 OPTION SELECTION FORM



taking care of our own

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

Important notes:

- Please complete this form when you are changing from your current option.
- Your employer must complete the employer acknowledgment section of this form (where applicable).
- **Please return this completed form to the Scheme by email to optionchange@mhcmf.co.za by Thursday, 31 December 2026.**
- In accordance with Scheme rules, option changes are effective from 1 January of a benefit year as long as the option change form is received by no later than 31 December. There will be no exception to this rule. **If you do not submit your option selection form timeously, you will remain on your current option.**
- Information on benefits and the Scheme rules are available on our website at www.mhcmf.co.za, or on request from our call centre on **0861 000 300**.

If you are changing your option, please provide us with your street address (not a PO box address); cell phone number and preferred email address in order for the Scheme to communicate with you.

PRINCIPAL MEMBER DETAILS

Membership number			
Title		Initials	Gender Male ☐ Female ☐
Full name and surname			
Date of birth	DD/MM/YYYY		
Identity/Passport number			
Country of issue			
Marital status			
SARS income tax number			
Street address			
		Postal code	
Telephone number (home)			
Telephone number (work)			
Cell phone number			
Preferred email address			

Please note: Should any of your dependants be over the age of 18, please provide their contact details below in order for the Scheme to contact them directly.

Full name and surname		Dependant code	
Street address			
		Postal code	
Cell phone number			
Preferred email address			
Full name and surname		Dependant code	
Street address			
		Postal code	
Cell phone number			
Preferred email address			

YOUR OPTION SELECTION FOR 2027

Please tick the option you are choosing for the next year. It is important that you read and understand the benefits of your chosen option, especially if you are changing to a lower option with less benefits. Benefits can be viewed on the website at www.mhcmf.co.za.

Please note: The Custom and Essential options are income based options. Please select the correct income band below based on your gross monthly income (before deductions). Should you not provide this proof, your contribution will be based on the highest income band until the Scheme receives your proof of income.

☐ Essential Option	→	Please tick your income band and attach a copy of your payslip/proof of income.	
☐ R0 - R3 954	☐ R3 955 - R8 479	☐ R8 480 - R12 429	☐ R12 430+
☐ Custom Option	→	Please tick your income band and attach a copy of your payslip/proof of income.	
☐ R0 - R4 199	☐ R4 200 - R7 599	☐ R7 600 - R11 099	☐ R11 100 - R13 699
☐ R13 700 - R15 599	☐ R15 600 - R18 499	☐ R18 500 - R24 999	☐ R25 000+
☐ Classic Option	☐ Classic Network Option		
☐ Hospicare Option	☐ Hospicare Network Option		
☐ Optimum Option			

DISCLOSURE OF PERSONAL INFORMATION

The privacy and security of your personal information (which includes the personal information of your dependants) are important to Moto Health Care ('the Scheme'). The Scheme 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. The Scheme 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.

The Scheme and its duly authorised service providers will only share personal information of our members and their dependants with third parties in accordance with the law and the Scheme rules, or if appropriate with the consent from the member or relevant dependant. The member consent form is available on our website at www.mhcmf.co.za. Consent may be withdrawn in writing at any time.

SIGNATURES

I, the undersigned, hereby confirm that the details provided in this form is true and correct.

Signature of principal member		Date	DD/MM/YYYY
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EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

Please note: Your employer must approve and sign this form, unless you are a continuation member.

I/We warrant that the principal member referred to in this form is an employee of our organisation.

Signed on behalf of the employer		Date	DD/MM/YYYY
Name of authorised signatory			
Designation			

09/2026