PO Box 2338, Durban 4000
Tel: 0861 000 300
Fax: 031 580 0478
Email: membership@motohealthcare.org.za

moto
HEALTH CARE

2017

CONTINUATION FORM

Important Notes:

- Membership will only be finalised upon completion of a fully completed application form.
- Incomplete forms will result in a delay.
- A change of option, addition/deletion of dependant/s may result in your contribution changing.
- A copy of the Scheme rules is available on request.

Please select the appropriate block:

☐ Retirement (copy of identity document)
☐ Retrenchment (copy of identity document)
☐ Death of principal member (surviving spouse to continue). Please attach a copy of the death certificate.
☐ Disability/ill health (copy of doctor's letter, pension fund notification, group notification)
☐ Maternity/temporary absence (copy of identity document, group notification)
☐ Individual

SECTION 1: PERSONAL PARTICULARS

Applicant

Membership Number

Title Initials First Name

Member Surname

Identity/Passport Number* Gender Male ☐ Female ☐

*If passport number, please supply date of birth

Date of Birth D D M M Y Y Y Y

Marital Status **Please mark applicable box with an 'X'** Single ☐ Married ☐ Divorced ☐ Widow(er) ☐

Physical Address

Postal Code

Postal Address

Postal Code

Telephone (home) Cellphone Number

Telephone (work) Monthly Income R

Email Address

PLEASE INDICATE YOUR PREFFERED METHOD OF COMMUNICATION WITH AN 'X' Email ☐ SMS ☐ Post ☐

No selection = posting of information

SECTION 2: BANKING DETAILS OF APPLICANT (only if member pays the contributions)

PLEASE DO NOT PROVIDE CREDIT CARD DETAILS. MOTO HEALTH CARE IS NOT ALLOWED TO RECORD YOUR CREDIT CARD DETAILS.

Your details will only be processed upon receipt of a valid copy of your identity document together with a certified letter from your bank validating your banking details.

Name of Account Holder

Bank and Branch Name

Account Number

Account Type Current ☐ Savings ☐ Transmission ☐ Deduction Day 0 1

Branch Code

SECTION 2: BANKING DETAILS OF APPLICANT (continued)

Please use this account for claims refunds Yes ☐ No ☐

Bank stamp

Moto Health Care may debit the above account with the amount due under the contract in accordance with the Moto Health Care debit order system. I/we agree to inform Moto Health Care in writing of any changes that take place. I/we authorise Moto Health Care to verify such account details with the financial institution. We accept that Moto Health Care may debit the account on a date other than the date specified.

Signature of Account Holder / Authorised Signatory

Date D D - M M - Y Y Y Y

SECTION 3: BANKING DETAILS FOR CLAIM REFUNDS PAYABLE TO MEMBER

This section must only be completed if claims refunds should be paid into an account different from the account used for collection of monies due by you.

PLEASE DO NOT PROVIDE CREDIT CARD DETAILS. MOTO HEALTH CARE IS NOT ALLOWED TO RECORD YOUR CREDIT CARD DETAILS.

Your details will only be processed upon receipt of a valid copy of your identity document together with a certified letter from your bank validating your banking details.

Name of Account Holder

Bank and Branch Name

Account Number

Account Type: Current ☐ Savings ☐ Transmission ☐

Branch Code

Signature of Principal Member

Date Membership to Start D D - M M - Y Y Y Y

SECTION 4: OPTION SELECTION (please mark applicable box with an 'X')

Please attach a copy of your payslip or proof of income if you have selected the Custom or Essential Option. This is mandatory. Should salary information be omitted, your contribution will be defaulted to the highest salary band.

OPTIMUM ☐

CLASSIC ☐

CLASSIC NETWORK ☐

HOSPICARE ☐

HOSPICARE NETWORK ☐

CUSTOM ☐ *Please attach a copy of payslip/income*

Income Band				
0 - R3 200	R3 201 - R5 800	R5 801 - R8 500	R8 501 - R10 500	> R10 501 +

ESSENTIAL ☐ *Please attach a copy of payslip/income*

Income Band			
0 - R3 000	R3 001 - R6 500	R6 501 - R9 500	> R9 501 +

SECTION 5: TERMS AND CONDITIONS

1. Rules of the Scheme

   1.1 The rules of the Scheme are available on **www.motohealthcare.org.za**, or can be requested by post or at the registered office of the Scheme.

   1.2 I apply for my dependant/s to join Moto Health Care ('the Scheme'). I have familiarised myself with the rules of the Scheme and bind myself and my dependants thereto.

   1.3 The rule of construction that a contract shall be interpreted against the party responsible for the drafting or preparation of the contract shall not apply.

   1.4 No amendment of this contract, including this clause, shall be of any force or effect, unless such amendment is made in writing and signed by both parties.

   1.5 No concessions by any party shall be considered to be a waiver or novation of such party's rights in terms of this contract and shall at all times be made without prejudice of such party's rights.

2. I acknowledge that if I or my dependant/s do not disclose all the information which is relevant to the assessment of this application, it will render any contracts to which this application relates null and void. In such an event, I will forfeit all contributions that I paid to the Scheme and the Scheme will have the right to reclaim any amounts that it may have paid to me, my dependant/s or any person on my or my dependant/s' behalf under such contracts.

3. Disclosure of Information

   3.1 In accordance with the Promotion of Access to Information Act (PAIA), the Scheme rules provide for all members to obtain relevant information from the Scheme. Members must complete the member consent form if they are not able to access the relevant information on the Scheme's website. The registered Scheme rules, as well as the latest annual financial statements submitted to the Council for Medical Schemes and approved by members at the Annual General Meeting, are available on our website at www.motohealthcare.org.za. Members can also obtain copies, at a nominal cost, at any of the walk-in centres listed in the member guide or by requesting an electronic version from a customer service agent on 0861 000 300.

   3.2 The Scheme can only provide personal and clinical information with written consent from the member. It is a contravention of the Protection of Personal Information (POPI) Act to do so without the consent of the person whose information is being requested. Please note that the Scheme will only provide information to another party where consent has been received. The member consent form is available on our website at www.motohealthcare.org.za.

   3.3 I am familiar with the conditions and the benefits of the option selected notwithstanding representation by any other party.

   3.4 I will notify the Scheme if any alteration takes place in any circumstances on which the Scheme based its assessment of its risk after the date of this application and before the date of the Scheme's acceptance of the risk (for example, prior to the birth of a dependant on the date of this application). I acknowledge that failure to do so will render any contracts to which this application relates null and void. In such an event, I will forfeit all contributions, which I paid to the Scheme and the Scheme will have the right to reclaim any amounts that it may have paid to me, my dependant/s or any person on my or my dependant/s' behalf under such contracts.

4. I understand that this application form is valid for 30 days only.

5. I am aware that the Scheme may ask for proof of identification at any stage.

6. It is my responsibility to ensure that the Scheme receives the monthly contribution for my membership as well as the membership of my dependant/s.

   6.1 Non-receipt by the Scheme of one month's contribution will result in suspension of medical benefits to me and my dependant/s. Such suspension will last until all arrear contributions have been brought up to date.

   6.2 Non-receipt by the Scheme of two months' contributions will result in cancellation of my and my dependant/s' membership to the Scheme.

7. If my employer is responsible to pay my medical scheme contributions, I have authorised and instructed, alternatively herewith authorise and instruct, my employer to:
   - deduct from my remuneration (and any other sums due to me) any amounts that I may owe to the Scheme from time to time; and
   - pay such amounts to the Scheme.

   7.1 I have authorised and instructed, alternatively herewith authorise and instruct any person (for example your employer), who holds funds for my benefit after I cease employment, to pay and continue to pay the amounts referred to in clause 7.1 to the Scheme as and when it is due.

8. All sums owing to the Scheme will be paid on demand. Failure to pay any debt due to the Scheme may result in the suspension or cancellation of my or my dependant/s' membership and/or handover to a third party for debt collection.

   8.1 I will pay all legal costs that may be incurred by the Scheme due to the recovery of any amount which I may owe to the Scheme or any other dispute of whatsoever nature which may arise from this application or the rules of the Scheme on an attorney and client scale.

9. The information that I have provided herein is complete and true. I understand that if my dependant/s or I am accepted as members of this Scheme, my answers herein provided will form the basis of such membership.

   9.1 The acceptance of this application as well as my continued membership or that of my dependant/s is further dependent on my and my dependant/s submission to any examination by the Scheme's medical assessor as and when the Scheme requires.

10. I realise that I must submit evidence of my own good health and that of my dependant/s to the Scheme.

11. The acceptance of my membership as well as the membership of my dependant/s is dependent on my provision of all information and evidence, currently and in future, to the Scheme as it may require from time to time.

   11.1 The Scheme may limit or exclude benefits for any particular ailment, disease, disorder, condition or disability that exists on the date of the Scheme's acceptance of risk.

   11.2 I herewith authorise the Scheme and/or Administrator and/or any contracted third party to obtain from any person any necessary information which they in their sole and absolute discretion may require concerning:

   11.2.1 any claim or risk assessment in relation to this application;
   11.2.2 my medical scheme membership;
   11.2.3 the medical scheme membership of my dependant/s.

   11.3 I herewith authorise and direct any person in possession of the above information or evidence to provide same to the Scheme and/or Administrator and/or contracted third party on request.

SECTION 5: TERMS AND CONDITIONS (continued)

11.4 I herewith authorise any medical doctor or other provider who attended me or my dependant/s in the past or who will attend me or my dependant/s in future, to provide the Scheme and/or Administrator and/or contracted third party with such information it may require on request.

11.5 For purposes of providing any of the above information or evidence, I herewith waive the provision of any law restricting the provision of such information.

12. In the case of new members of the Scheme, the following may apply:
    - A three-month general waiting period.
    - A 12-month exclusion on a pre-existing condition.
    - Late joiner contribution penalty.

13. I will notify the Scheme if I know of any of my dependants that are living with HIV/AIDS.

14. Pre-authorisation

    I will notify the Scheme should any of my dependant/s require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits payable by the Scheme for any procedure undertaken.

    No benefit will be payable by the Scheme unless it is satisfied by the validity of a claim and it has received all information required.

15. I undertake to provide 30 days' written notice should I wish to terminate my membership or that of my dependant/s.

16. I undertake to obtain the necessary consent from any of my dependant/s to whom these conditions may apply and hereby indemnify the Scheme and/or Administrator against any claim which may arise as a result of my failure to do so.

17. Words used in this application have the meaning that the rules give them.

18. I consent to the recording of all conversations between me, my dependant/s and the Scheme or the Administrator, and all information obtained through these conversations will form part of the Scheme's and the Administrator's records. I further consent to all these records remaining the sole property of the Scheme and the Administrator.

19. If my dependant/s and myself are accepted as members, the registered rules of the Scheme are binding on me and my dependant/s.

20. I acknowledge that my dependant/s over the age of 12 years are aware that information regarding their health can be submitted to Moto Health Care.

21. I acknowledge that Moto Health Care and I indemnify the Scheme against any claim which may arise as a result of my failure to do so.

22. I acknowledge that me and/or my dependant/s are also aware and fully understand the abovementioned.

SECTION 6: ONLINE ACCESS

1. I accept that Moto Health Care will not in any way be responsible or liable for any claims of any nature whatsoever made by anyone (myself excluded), which arise as a result of my failing to keep my password and username secure and confidential to myself.
2. I indemnify Moto Health Care against any such claims.
3. I understand that this service may not be available 24 hours a day.

Signed at

Name of Signatory

Signature of Principal Member

Date D D - M M - Y Y Y Y

MOMENTUM HEALTHSAVER PRODUCT

Should you wish to add on the Momentum HealthSaver product, kindly complete the enclosed application form and email the completed form to membership@motohealthcare.org.za.

momentum

Application for HealthSaver

2017

Important notes:

- As a Moto Health Care member, you can choose to make use of additional products available from Momentum Group (Momentum), a division of MMI Group Limited, to seamlessly enhance your medical aid. Please note that Momentum is not a medical scheme, and is a separate entity to Moto Health Care.
- Please submit the completed and signed form via fax to **031 580 0478** or email at **membership@motohealthcare.org.za.**
- For any enquiries, please contact Moto Health Care on **0861 000 300.**

Group number

Employer name

Membership number

Principal member's name

Principal member's surname

Section 1: Financial adviser (where applicable)

Name	Financial adviser's code	Broker house code	Commission ref no

Signature of financial adviser

Date D D – M M – 2 0 Y Y

Section 2: Monthly HealthSaver

☐ Tick this box if you want to start contributing to your HealthSaver and complete your chosen amount below. Please also complete Section 3 and Section 4.

Monthly amount R Minimum of R100 per month

You can choose to contribute any amount in addition to the regular monthly payments. These additional amounts can be paid via Electronic Fund Transfer (EFT).

Section 3: Contribution payer information

(Please do not provide credit card details. Momentum is not allowed to record your credit card details)

Name of account holder

Name of bank

Account number

Account type Current/Cheque ☐ Savings ☐ Transmission ☐

Branch code - - - Branch name

Section 4: Authorisation for contribution collection

Completion of this section is compulsory for all contribution payers

I authorise Momentum to debit the account as supplied on this application form with the amount of the contribution that I have agreed to pay per complementary product. I undertake to inform Momentum of any change in the account details. I authorise Momentum to verify such account details with my financial institution. I accept that Momentum may debit the account on a date other than specified.

If an **individual's** account is to be debited:

Signature of account holder | **Date** D D – M M – 2 0 Y Y

If a **company** account is to be debited:

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- Momentum may bill us for the amount due for this member in the same manner as for other members that our organisation employs.

Name

Position in company

Signature of account holder/ Authorised signatory | **Date** D D – M M – 2 0 Y Y

Company stamp

Section 5: Terms and conditions

Please read the clause below carefully. It contains provisions that may impact on your rights.

1. I agree to be bound by the Rules and Conditions that apply to the HealthSaver and the terms and conditions of the loan agreement as set down in the Rules and Conditions.
2. I have been provided with a copy of the Rules and Conditions and I have been given an opportunity to consider, familiarise myself with and agree to the Rules and Conditions.
3. I appoint Momentum as my agent for the purpose of collecting and depositing all contributions in respect of the HealthSaver and for making the relevant payments as per the Rules and Conditions.
4. I acknowledge that:
   i. In doing so, Momentum acts as my agent
   ii. I assume all risks connected with the administration of the entrusted funds by Momentum, understanding that Momentum is bound by the Protection of Funds Act, 2001.
   iii. I will direct all enquiries in respect of the HealthSaver to Momentum

I have read and understand the above clause, have had an opportunity to question and consider it and I agree to the consequences of it.

Signed at | Starting date 0 1 – M M – 2 0 Y Y

(The start date cannot be before the Moto Health Care start date.)

Signature of investor | **Date** D D – M M – 2 0 Y Y

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
Reg. No. 1904/002186/06 Momentum, a division of MMI Group Limited, an authorised financial services and credit provider