PO Box 2338, Durban 4000
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moto
HEALTH CARE

2017

MEMBERSHIP RECORD AMENDMENT

Important Note:

- Your employer must sign this record amendment form, unless you are an individual member.

MEMBER DETAILS (This is very important)

Member Number

Member First Name

Member Surname

Employee Number

REQUEST FOR (please tick relevant box)

☐ Change of Address - **Section 1**

☐ Termination of Dependant/s - **Section 2**

☐ Termination of Principal Member - **Section 3**

SECTION 1: CHANGE OF ADDRESS

Please advise us of your new address below

Contact Details

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (home)

Telephone (work)

Cellphone Number

Email Address

SECTION 2: TERMINATION OF DEPENDANT/S

Please complete the information of the dependant/s that you would like to terminate

Effective Date D D - M M - Y Y Y Y

DEPENDANT 1

Surname

First Name

Gender M ☐ F ☐ Date of Birth D D - M M - Y Y Y Y

Identity Number

Relationship

SECTION 2: TERMINATION OF DEPENDANT/S (continued)

Effective Date D D - M M - Y Y Y Y

DEPENDANT 2

Surname

First Name

Gender M F Date of Birth D D - M M - Y Y Y Y

Identity Number

Relationship

Reason for Termination
(Please tick)

- Self-supporting
- Death (please supply death certificate)
- Divorce
- Marriage
- Transfer to a new medical scheme
- Overseas
- Other (please specify)

SECTION 3: TERMINATION OF PRINCIPAL MEMBER

Effective Date D D - M M - Y Y Y Y

Reason for Termination (Please tick)

- Change of employment
- Marriage
- Dismissed
- Retirement
- Transfer to new medical scheme

Name of new medical scheme

(required for transfer of positive savings balance, if applicable)

- Death (please supply death certificate)
- Divorced/Separated
- Financial reasons
- Retrenchment
- Left company (no longer employed)
- Left Scheme due to DSP
- Left Scheme due to underwriting
- Left Scheme due to product
- Left Scheme due to service
- Maternity
- Transfer to new Group (**Important:** please complete a change in group form)

Member Number

If other, please specify

I am not joining another medical scheme, therefore, please could you pay out the savings to the following banking account:

Name of Bank

Account Number

Type of Account Current Savings Transmission

Branch Code Branch Name

Please find attached a copy of my identity document/passport document.

Would you like to continue membership with Moto Health Care? Yes No

If 'Yes', please provide address to which the application form must be sent to:

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

To be signed by an employer representative if the company 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 member in the same manner as for other members that our organisation employs.

Name			
Surname			
Signature of Account Holder		Date	D D - M M - Y Y Y Y
Signature of Employer		Date	D D - M M - Y Y Y Y
Company Stamp			