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

moto HEALTH CARE

2017

APPLICATION FOR MEMBERSHIP

Important Notes:

- Membership will only be finalised upon completion of a fully completed application form.
- Incomplete forms will result in membership being delayed.
- Identity documents, birth certificates and marriage certificates are required for principal member and dependant/s.
- Changes to option selections may be only be made annually with effect from 1 January each year.
- A copy of the Scheme rules is available on request.
- Are you aware of any situation which may change your membership in the next 12 months, e.g. marriage or birth of a child?

PERSONAL PARTICULARS

APPLICANT

Title | Initials | Gender | Male | Female

Surname

First Name

Date of Birth (D D M M Y Y Y Y) | Identity Number/Passport Number

PLEASE MARK APPLICABLE BOX WITH AN 'X' Single | Married | Divorced | Widow(er)

CONTACT DETAILS

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (h)

Telephone (w)

Cellphone

Email Address

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

No selection = posting of information

SPOUSE

Title | Gender | Male | Female

Surname

First Name

Date of Birth (D D M M Y Y Y Y) | Identity Number/Passport Number

Relationship

Telephone (h)

Telephone (w)

Cellphone

Please note: We reserve the right to request additional information if required

PERSONAL PARTICULARS (continued)

DEPENDANT 1

Surname

First Name

Gender Male ☐ Female ☐

Date of Birth D D M M Y Y Y Y Identity Number/Passport Number

Relationship

DEPENDANT 2

Surname

First Name

Gender Male ☐ Female ☐

Date of Birth D D M M Y Y Y Y Identity Number/Passport Number

Relationship

DEPENDANT 3

Surname

First Name

Gender Male ☐ Female ☐

Date of Birth D D M M Y Y Y Y Identity Number/Passport Number

Relationship

DEPENDANT 4

Surname

First Name

Gender Male ☐ Female ☐

Date of Birth D D M M Y Y Y Y Identity Number/Passport Number

Relationship

IF A DEPENDANT IS NOT LIVING WITH YOU, PLEASE PROVIDE AN ADDRESS

Dependant No.

Physical Address

Postal Code

Dependant No.

Physical Address

Postal Code

Dependant No.

Physical Address

Postal Code

Dependant No.

Physical Address

Postal Code

UNDERWRITING QUESTIONS

PLEASE ANSWER 'YES' OR 'NO' TO EACH QUESTION ('Y' or 'N')

If 'YES', please provide detailed information of medical condition and treatment.

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease						
2	Cystic fibrosis						
3	Obstructive lung disease (asthma, emphysema or COAD)						
4	Diabetes (insulin or non-insulin dependent diabetes mellitus)						
5	Hypo- or hyperthyroidism						
6	Arthritis (i.e. osteo- or rheumatoid arthritis or gout) - all related musculoskeletal conditions						
7	Osteoporosis						
8	Gastro-oesophageal reflux disease (GORD/heartburn) or stomach/duodenal ulcers (please circle)						
9	Immune deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies, etc.)						
10	Anaemia or abnormalities of clotting mechanism - haemophilia, thrombosis, bleeding disorder						
11	Hormone replacement therapy, endometriosis or ovarian cysts						
12	Depression and/or anxiety disorders, anorexia, attention deficit disorder, Alzheimer's disease						
13	Any nervous or mental complaint (e.g. epilepsy, blackouts, paralysis or headaches)						
14	Glaucoma, cataracts or any other disorders of the eye						
15	Parkinson's disease or multiple sclerosis (please circle)						
16	Hyperplasia of prostate (BPH) or prostatism						
17	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)						
18	Urinary tract infection or calculi (stones)						
19	Back or neck-related condition (lumbago, sciatica, injury, spasm, loss of limb, previous surgery)						
20	Are you pregnant? If so, how many weeks?						
21	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?						
22	Are you on any medication at present?						
23	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical scheme claim within the next 12 months?						
24	Skin conditions/disorders (e.g acne, eczema, psoriasis, etc.)						
25	Ear, nose or throat disorders (e.g. ear discharge, recurrent tonsillitis, hearing/speech impediments)						
26	Infectious diseases (e.g. tuberculosis, shingles, measles, etc.)						
27	Malignant neoplasms (cancer, growths or malignant tumours)						
28	Benign neoplasms (non-malignant tumours/growths)						
29	Specialised dentistry, maxillofacial treatment, dental problems, gum disease						
30	Have you had or are you expecting to have plastic or reconstructive surgery?						
31	Any hereditary or congenital conditions, e.g. Down's syndrome						
32	Connective tissue disorders, e.g. systemic lupus						
33	Do you or your dependants take part in any professional or dangerous sports?						
34	Any other symptoms or illnesses that were not specifically diagnosed by a doctor or for which no specific treatment was provided for any of my dependants or me.						

* Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership number, you have 14 working days to fax confirmation of your HIV/AIDS status to our HIV/AIDS Department on **0866 093 792** to ensure registration on the HIV Management Programme. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation.

Alternative contact details:

Telephone: 0860 109 793
Alternative Fax Number: 012 675 3848
Cellphone: 082 821 0994
Email Address: ha@motohealthcare.org.za

UNDERWRITING QUESTIONS (continued)

PLEASE PROVIDE DETAILS BELOW IF YOU HAVE ANSWERED 'YES' TO ANY OF THE UNDERWRITING QUESTIONS

Question No.	Nature and duration of complaint and full details of treatment and/or medication being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment?

1. Underwriting may be applied to this application.
2. Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and/or membership being terminated.
3. Please note that this medical questionnaire does not constitute an application to register, authorise chronic medication, prescribed minimum benefit (PMB) services or planned procedures. You need to obtain authorisation for these by contacting 0861 000 300 once your membership has been finalised.
4. For further details please refer to the latest member guide.

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

Please attach a copy of your payslip or proof of income if you are selecting the Custom Option or Essential Option. This is mandatory.

OPTIMUM ☐

CLASSIC ☐

CLASSIC NETWORK ☐

HOSPICARE ☐

HOSPICARE NETWORK ☐

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

ESSENTIAL ☐ *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 +

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

BANKING DETAILS OF APPLICANT (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.

Name of Account Holder

Bank and Branch Name

Town

Account Number

Account Type Current ☐ Savings ☐ Transmission ☐ Branch Code

Please use this account for claims refunds Yes ☐ No ☐

BANKING DETAILS OF APPLICANT (for claims refunds)

This section must only be completed if claims refunds should be paid into an account different from above.

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

Name of Account Holder

Bank and Branch Name

Town

Account Number

Account Type Current ☐ Savings ☐ Transmission ☐ Branch Code

ACCESS TO INFORMATION

Would you like access to your information on the Moto Health Care website? Yes ☐ No ☐

Email Address

Preferred Username

EMPLOYER INFORMATION

Name of Employer

Group Number

Applicant's Employee No.

Applicant Employment Date D D M M Y Y

Applicant's Occupation

Date Membership is to start 0 1 M M Y Y

Salary R

Business Telephone No.

Employer Email Address

ALL INFORMATION PROVIDED HEREIN IS CERTIFIED CORRECT

It is hereby confirmed that the applicant is in our employ and commenced employment on the date indicated above.

Signed on Behalf of the Employer

Company Stamp

Name of Signatory

Designation

Date D D - M M - Y Y Y Y

DETAILS OF FINANCIAL ADVISOR (where applicable)

Broker Name C A R L A H A S K I N S

CMS Number

Telephone Number 0 3 1 2 4 2 6 8 0 0

FSB Licence Number

Brokerage Name C O M P E N D I U M I N S U R A N C E B R O K E R S

CMS Number

Telephone Number

FSB Licence Number

Signature

Date D D - M M - Y Y Y Y

Disclaimer: The Scheme will pay the agreed commission to the Scheme's appointed broker only.

The Scheme has an agreement with certain brokerages and not with individual brokers. Commission is therefore, paid to the brokerage for the servicing of members.

WAITING PERIODS

Moto Health Care reserves the right to underwrite all applications according to the rules and regulations set out in the Medical Schemes Act (Act 131 of 1988) that prevail at the time of the application. These include the imposition of a three-month general waiting period (all benefits), a 12-month waiting period on pre-existing sickness conditions and late joiner premium penalties.

PREVIOUS MEDICAL SCHEME INFORMATION OF PRINCIPAL MEMBER, SPOUSE AND DEPENDANTS

Please detail previous medical scheme membership and certificates of membership (membership cards are not accepted), which are required in order to avoid late joiner penalties, waiting periods and condition-specific exclusions.

Name of Scheme	Membership No.	On Date	Off Date	Name of Employer

TERMS AND CONDITIONS

1. Rules of the Scheme

   1.1 The rules of the Scheme are available at **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 dependant/s 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 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.

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.

TERMS AND CONDITIONS (continued)

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.

    11.4 I herewith authorise any medical doctor or other provider who attended to me or my dependant/s in the past or who will attend to 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.

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.

DECLARATION OF HEALTH

- The answers given herein are full, complete and true and, if I am accepted as a member of Moto Health Care, will constitute the basis of my membership.
- I realise that I must submit evidence of the good health of myself and my dependant/s and that benefits may be limited or excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date.
- I am bound now, and in the future, if my dependant/s and myself are accepted as members, to give Moto Health Care all such information and evidence as Moto Health Care may from time to time require and to this end authorise the medical practitioner or other provider who has attended to me in the past or who will attend to me in the future, to provide Moto Health Care with such information as Moto Health Care may require, hereby waiving the provisions of any law or regulation restricting the provision of such information.
- Words used in this application shall bear the meaning ascribed to them in the Rules.
- I hereby consent to the disclosure by the Scheme of any information supplied by third parties provided that such parties agree to keep such information confidential at all times.

Signature

Date D D - M M - Y Y Y Y

Signed by me as the applicant declaring that I have carefully read this application form and accepting that the fact that I have applied does not necessarily mean that I will be accepted as a member.

APPLICATION CHECKLIST

IMPORTANT
We cannot process your application if it is incomplete, incorrect, or you have not attached the relevant documents.
Please use the checklist below as a guideline to ensure that all the relevant documentation has been provided.

- ☐ Have you completed all the sections relevant to your application?
- ☐ Have you given us the correct contact details?
- ☐ Do we have your banking details so that we can collect your contributions and pay your claim refunds?
- ☐ Have you signed the form? (unsigned forms will be returned to you for signature)
- ☐ If applicable, has your broker or intermediary completed and signed the relevant section of this form?
- ☐ Have you provided your employer's details?
- ☐ Have you chosen one option only?

Have you given us the following documentation where applicable?

- ☐ Identity documents/passports of principal member as well as dependant/s
- ☐ Birth certificate
- ☐ Proof of taxable income (e.g. pay slip)
- ☐ Proof of full-time student registration
- ☐ Legal adoption forms (if children are adopted)
- ☐ Membership certificate with end dates
- ☐ Marriage certificate
- ☐ Affidavit (should any dependant/s surname differ from principal member's surname)
- ☐ Copy of cancelled cheque or bank statement for collecting contributions and/or claim refunds
- ☐ Certified letter from your bank validating your banking details