

Section 3 - Termination of Principal Member

Effective Date

Reason for termination

| | | | | | |
|-----------------------------|--------------------------|---|--------------------------|---------------------------------|--------------------------|
| Change of employment | <input type="checkbox"/> | Death (please supply death certificate) | <input type="checkbox"/> | Left Scheme due to DSP | <input type="checkbox"/> |
| Marriage | <input type="checkbox"/> | Divorced/Separated | <input type="checkbox"/> | Left Scheme due to Underwriting | <input type="checkbox"/> |
| Dismissed | <input type="checkbox"/> | Financial reasons | <input type="checkbox"/> | Left Scheme due to Product | <input type="checkbox"/> |
| Retirement | <input type="checkbox"/> | Retrenchment | <input type="checkbox"/> | Left Scheme due to Service | <input type="checkbox"/> |
| Transfer to new medical aid | <input type="checkbox"/> | Left company (no longer employed) | <input type="checkbox"/> | | |

If other please specify _____

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 _____

Declaration

I declare that to the best of my knowledge the information provided is true, correct and complete.
Please Note: HR must sign this Record Amendment Form, unless you are an individual member.

Members signature _____

Date _____

Signature of employer representative _____

Date _____

COMPANY STAMP

