moto
HEALTH CARE

Administered by :
Momentum Medical Scheme Administrators
PO Box 2338, Durban, 4000
Tel: 0861 000 300
Fax: 031 580 0525

APPLICATION FOR MEMBERSHIP

PERSONAL PARTICULARS

APPLICANT

Surname

First name

Gender M F

Date of Birth D D M M Y Y Y Y

I.D.No.

MARK APPLICABLE BOX WITH AN "X"

Single Married Divorced Widow(er)

CONTACT DETAILS

Postal Address

Code

Physical Address

Code

Telephone (H)

Telephone (W)

Cell:

E-mail

An affidavit is required for all dependants other than spouse and own children.
- if parents, we require proof of income.
- if financially dependant other children, brothers, sisters, grandchildren, we require a death certificate of parents.

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

SPOUSE

Surname

First Name

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

Identity No.

Relationship

DEPENDANT 1

First Name

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

Identity No.

Relationship

DEPENDANT 2

First Name

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

Identity No.

Relationship

DEPENDANT 3

First Name

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

Identity No.

Relationship

DEPENDANT 4

First Name

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

Identity No.

Relationship

UNDERWRITING QUESTIONS

PLEASE ANSWER "YES" OR "NO" FOR EVERY QUESTION ("Y" or "N")

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholestrol or lipids, Ischaemic heart disease, Heart failure, Angina, Stroke (CVA) or Peripheral vascular disease.						
2	Obstructive lung disease (asthma, emphysema or c.o.a.d)						
3	Diabetes (insulin or non-insulin dependant diabetes mellitus)						
4	Hypo or hyperthyroidism						
5	Arthritis, i.e. osteo, rheumatoid arthritis or gout all related musculoskeletal conditions						
6	Osteoporosis.						
7	Gastro-Oesophageal reflux disease (gord/heartburn) or stomach or duodenal ulcers (please circle)						
8*	Immune deficiency states i.e. hiv/aids*, immunoglobulin deficiencies						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone replacement therapy, endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint e.g epilepsy, blackouts, paralysis or headaches.						
13	Glaucoma , cataracts or any other disorders of the eye.						
14	Parkinson's disease or Multiple Sclerosis (please circle where applicable)						
15	Hyperplasia of prostate (BPH) or prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm etc)						
19	Are you pregnant, if so how many weeks?						
20	Have you had any surgical procedure during the past 12 months or planning a surgical procedure for the following 12 months						
21	Are you on any medication at present?						
22	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 aid claim within the next 12 months.						
23	Skin conditions/disorders e.g Acne, Eczema, Psoriasis etc.						
24	Ear, nose or throat disorders, e.g. ear discharge, recurrent tonsillitis?						
25	Infectious diseases e.g Tuberculosis. Shingles, measles etc,						
26	Malignant neoplasms (Cancer, growths or malignant tumours)						
27	Benign Neoplasms (non malignant tumours/growths)						
28	Specialized dentistry /maxillo facial treatment.						
29	Have you had or are you expecting to have Plastic or reconstructive surgery.						

* Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership (contract) number we require you to please fax confirmation of your HIV/Aids status to our HIV/Aids Department on (031) 580 0484. 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.

Question No.	Nature and duration of complaint and full details of treatment 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 ?

NB: Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and /or membership terminated.

OPTION SELECTION

Please select by placing a tick in the relevant box.
NB: Changes may only be made annually with effect from 1 January each year.

Optimum	
Classic	
Hospicare	
Custom	
Essential	

BANKING DETAILS OF APPLICANT (for direct payment of monies due to you)

Name of Account Holder

Branch Number

Bank & Branch Name

Account Number

Account Type (C = Current, T = Transmission, S = Savings

BANKING DETAILS OF APPLICANT (for payment of monthly contributions due by you)

Name of Account Holder

Branch Number

Bank & Branch Name

Account Number

Account Type (C = Current, T = Transmission, S = Savings

ONLINE DATA ACCESS

Would you like access to your information on the Moto Health Care Website? **Y** **N**

E-mail Address

Preferred User Name

EMPLOYER INFORMATION

Name of employer

Applicant's employee number

Applicant commenced employment on

Applicant's occupation

Date membership is to start

Salary

Business telephone number

ALL INFORMATION HERETOFORE GIVEN IS CERTIFIED CORRECT

SIGNED ON BEHALF OF THE EMPLOYER

SIGNATURE

NAME OF SIGNATORY

DATE

COMPANY STAMP

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 3 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

Please detail previous medical scheme membership

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

Please attach certificates of membership (not membership cards) which are required in order to avoid late joiner penalties, waiting periods and condition specific exclusions

ACKNOWLEDGEMENTS

1. I acknowledge that I am aware of the provisions of your Rules dealing with the submission of fraudulent claims to the scheme, the commission of fraudulent acts and the non-disclosure of material information to the Scheme. In particular, I am aware that I am not permitted to allow any person other than my registered dependants to use my membership card.
2. I am aware that, if I am accepted for membership, your Moto Health Care will be binding on me and that, in the case of a dispute, the registered rules will be decisive.
3. I hereby authorise and instruct my Employer to deduct from my remuneration and any other sums due to me (any amounts which may be due by me to a pension fund or provident fund) who holds funds for my benefit after I cease employment to pay, and continue to pay, the amounts referred to in the first sentence hereof to Moto Health Care as and when they fall due. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to the Schemes.
4. I am aware that proof of identification may be requested at any stage.
5. All sums due by me to Moto Health Care shall be forthwith due and payable by me to Moto Health Care on demand.
6. If I am accepted as a member, I must, both now and in future, give the Scheme all such information and evidence as it may require from time to time. For this purpose, authorise the Scheme and/or the Administrator and/or my financial advisor to obtain from any person any necessary information that they in their sole and absolute discretion may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or regarding my medical scheme membership and I direct that person to provide the Scheme and/or the Administrator and/or financial adviser with such information on request. I authorise any medical doctor or other provider who has attended me in the past or who will attend me in the future to provide the Scheme and/or the Administrator with such information as it may require. I therefore waive the provisions of any law or regulation that restricts the giving of such information. I understand that I must also submit to any examination by the Scheme's medical assessor as and when the Scheme requires this.

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 user name secure and confidential to myself.
2. I indemnify Moto Health Care and hold it harmless against any such claims.
3. I understand that this service may not be available 24 hours a day.

DECLARATION

1. 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.
2. I realise that I must submit evidence of the good health of myself and my dependants 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.
3. I am bound now, and in the future, if I am accepted as a member, 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 me in the past or who will attend 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 giving of such information. I must also submit as and when required by Moto Health Care to examination by Moto Health Care's Medical Assessor.
4. Words used in this application shall bear the meaning ascribed to them in the Rules.

Signature ______________________ Date ______________________

Signed by me as 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.

Membership will only be awarded upon receipt of a fully completed application form.
Incomplete forms will be sent back to you.