

OPTION SELECTION FORM 2026



Telephone: 0861 000 300 | Email: optionchange@mhcmf.co.za

taking care of our own

Important notes:

- Please complete this form when you are changing from your current option.
- Your employer must complete the employer acknowledgement section of this form (where applicable).
- **Please return this completed form to the Scheme by email to optionchange@mhcmf.co.za by Wednesday, 31 December 2025.**
- In accordance with Scheme rules, option changes are effective from 1 January of a benefit year as long as the option change form is received by no later than 31 December. There will be no exception to this rule. **If you do not submit your option selection form timeously, you will remain on your current option.**
- Information on benefits and the Scheme rules are available on our website at www.mhcmf.co.za, or on request from our call centre on 0861 000 300.

If you are changing your option, please provide us with your physical address (not a PO box address); cell phone number and email address in order for the Scheme to communicate with you.

PRINCIPAL MEMBER DETAILS

Membership number	<input type="text"/>			
Title	<input type="text"/>	Initials	<input type="text"/>	
Full name and surname	<input type="text"/>			
SARS income tax number	<input type="text"/>	Marital status	<input type="text"/>	
Identity/Passport number	<input type="text"/>	Date of birth	<input type="text"/> DD/MM/YYYY	
Physical address	<input type="text"/>			
Telephone number (home)	<input type="text"/>	Telephone number (work)	<input type="text"/>	
Cell phone number	<input type="text"/>			
Email address	<input type="text"/>			
Gender	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>

Please note: Should any of your dependants be over the age of 18, please provide their contact details below in order for the Scheme to contact them directly.

Full name and surname	<input type="text"/>		
Dependant code	<input type="text"/>	Cell phone number	<input type="text"/>
Physical address	<input type="text"/>		
Email address	<input type="text"/>		
Full name and surname	<input type="text"/>		
Dependant code	<input type="text"/>	Cell phone number	<input type="text"/>
Physical address	<input type="text"/>		
Email address	<input type="text"/>		
Postal code	<input type="text"/>		
Postal code	<input type="text"/>		

YOUR OPTION SELECTION FOR 2026

Please tick the option you are choosing for the next year. It is important that you read and understand the benefits of your chosen option, especially if you are changing to a lower option with less benefits. Benefits can be viewed on the website at www.mhcmf.co.za.

Please note: The Custom and Essential options are income based options. Please select the correct income band below based on your gross monthly income (before deductions). Should you not provide this proof, your contribution will be based on the highest income band until the Scheme receives your proof of income.

ESSENTIAL OPTION

ESSENTIAL INCOME BANDS			
R0 - R3 800	R3 801 - R8 154	R8 155 - R11 952	R11 953+

Please tick your income band and attach a copy of your payslip/proof of income.

CUSTOM OPTION

CUSTOM INCOME BANDS					
R0 - R4 047	R4 048 - R7 297	R7 298 - R10 664	R10 665 - R13 174	R13 175 - R17 802	R17 803+

CLASSIC OPTION

CLASSIC NETWORK OPTION

HOSPICARE OPTION

HOSPICARE NETWORK OPTION

OPTIMUM OPTION

DISCLOSURE OF PERSONAL INFORMATION

The privacy and security of your personal information (which includes the personal information of your dependants) are important to Moto Health Care ('the Scheme'). The Scheme will only process personal information, which includes collecting, using, storing and sharing such information, in accordance with its [Privacy Policy](#) and if the processing is permitted by law, for a legitimate interest or otherwise with your consent. The Scheme will share your personal information with its agents (such as its Administrator and managed healthcare organisations) who assist it to administer your membership and provide you and your dependants with membership benefits.

The Scheme and its duly authorised service providers will only share personal information of our members and their dependants with third parties in accordance with the law and the Scheme rules, or if appropriate with the consent from the member or relevant dependant. The member consent form is available on our website at www.mhcmf.co.za. Consent may be withdrawn in writing at any time.

SIGNATURES

I, the undersigned, hereby confirm that the details provided in this form is true and correct.

Signature of principal member

Date

DD/MM/YYYY

EMPLOYER ACKNOWLEDGEMENT OF CHANGE IN BENEFIT

Please note: Your employer must approve and sign this form, unless you are a continuation member.

I/We warrant that the principal member referred to in this form is an employee of our organisation.

Signed on behalf of the employer

Date

DD/MM/YYYY

Name of authorised signatory

Designation

09/2025

