FORM H

AFFIDAVIT FOR MONTHLY INCOME OF PENSIONERS

PLEASE COMPLETE IN BLOCK LETTERS.

It is imperative that all sections of this form be completed in full. Failing to do so will cause a delay in the processing of the request, as the incomplete form will be returned to the applicant.

Once the form has been completed, it should be returned to <u>membership@imperialmotusmed.co.za</u>. You may also fax it to 0860 111 788 or post it to PO Box 2287, Bellville 7535.

If you require assistance in completing this form, please call 0860 467 374.

1. PERSONAL DETAILS OF PRINCIPAL MEMBER (COMPULSORY TO COMPLETE)									
Member number	Title								
Surname									
First name(s)	Initials								
Identity/Passport number									

2. AFFIDAVIT - DETAILS OF MONTHLY INCOME

I declare that my monthly income is	R	and consists c	of the follo	wing:						
Monthly pension	Investments	Annuitie	S		Othe	er				
If other, please specify:										
 I,, confirm that all of the information is true in every respect. I understand and agree that the consequence of submitting inaccurate information could result in the: forfeiture of all benefits from the Scheme; refunding in full all amounts for benefits/services paid on my behalf by Imperial Motus Med; and waiving of my right to claim a refund for any contributions paid by me to Imperial Motus Med. 										
Signed at		on the	DAV	of		MONTH	YEAR			
			DAY			MONTH	YEAR			
Member's signature	gnature Commissioner of Oaths									
Date		_								
	DD/MM/YYYY									

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