FORM B

AFFIDAVIT FOR REGISTRATION/CONFIRMATION OF PRINCIPAL MEMBER'S PARENT/BROTHER/SISTER/ CHILD/OTHER DEPENDANT (OVER THE AGE OF 21)

Imperial™ Motus Med

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 membership@imperialmotusmed.co.za. 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 (if you are an existing member) Title

Surname

First name(s) Initials

Identity/Passport number

2. PERSONAL DETAILS OF PARENT/BROTHER/SISTER/CHILD/OTHER DEPENDANT OVER THE AGE OF 21

Title Surname

First name(s) Initials

Identity/Passport number Relationship

3. AFFIDAVIT – PARENT/BROTHER/SISTER/CHILD/OTHER DEPENDANT OVER THE AGE OF 21

Registration/confirmation of PARENT/BROTHER/SISTER/CHILD OR OTHER DEPENDANT OVER THE AGE OF 21 as a dependant of the principal member is subject to:

- the principal member being liable for financial care and support;
- the person not being a registered dependant on another medical scheme; and
- the person not being in receipt of a monthly income greater than R6 550.

3.1 What is the reason for wanting to register the dependant on Imperial Motus Med or confirming dependency?

3.2 If the dependant receives an income of any kind, please indicate how much per month. R

3.3 Are you solely responsible for the dependant's daily living expenses? Yes No

3.4 What is your monthly expenditure in respect of the dependant? R

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.

3. AFFIDAVIT – PARENT/BROTHER/SISTER/CHILD/OTHER DEPENDANT OVER THE AGE OF 21 – CONTINUED

Signed at _____ on the _____ of _____ _____
DAY MONTH YEAR

Member's signature

Dependant's signature (optional)

Commissioner of Oaths

Date _____
DD/MM/YYYY

OFFICIAL STAMP OF THE COMMISSIONER OF OATHS