FORM M





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.

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

Only employees of Imperial Limited and Motus Holdings Limited who are members of Imperial Motus Med at the time of retirement are eligible to continue as pensioner members.

1. PERSONAL DETA	AILS	5 OI	FΡ	RIN	CIP	AL	ME	MB	ER	(CC	MF	UL	SO I	₹Y .	ГО	CON	ИPL	EΤ	E)									
Member number																								1	itle			
Surname																												
First name(s)																								Init	ials			
Identity/Passport number																												
Telephone numbers											Wo	ork						Hor	ne									
											Ce	ll nu	mbe	г														
Email address																												
Postal address																												
																								Co	ode			
2. BANKING DETA Please attach a copy of you Name of account holder Account number Name of bank Branch name) and	d a b	pank	stat	eme	ent o	r sta	mpe	ed le	tter	from	n you	ır ba	ink ((not	olde	r tha	an th	nree	mor	nths)						
Eight-digit branch code																												
Account type		Cur	rent			Sav	vings			Tra	nsmi	ssior	n		Che	eque												
Imperial Motus Med is here Please note: Contributions							banki	ng a	ccou	nt w	ith th	ne m	onth	lly co	ontrit	outio	ns pa	aid t	o Im	peria	al an	d Mo	tus A	лedi	cal A	id.		
Signature of account holder												-					Da	te _				ı	DD/N	ΛM/	YYYY			

MEMBER NUMBER																									
3. OPTION SELECTION																									
Please indicate which plan you prefer by	tickin	g on	e of	the	boxe	es be	low	- yo	ou m	ay o	nly	choc	ose o	ne.											
Imperial Motus Med Health Plan		lm	nperi	al M	otus	Med	Bud	get	Plan																
		-																							
4. CHOICE OF NETWORK GENE	RAL	PR	AC	TITI	ON	ER	10)	VLY	AP	PLI	CA	BLE	IF	Y0	U C	НО	OS	E TH	IE E	UC)GE	ΓΡ	LAI	N)	
If you chose to be on the Imperial Motus I use of:	Med B	Budg	et P	lan,	plea	se pr	ovic	le th	ie de	tails	of	one (or tw	vo g	ener	al pı	acti	tione	ers yo	ou v	vould	l like	e to	mak	e
General practitioner 1																									
General practitioner's name and surname																									\mathbb{L}
Practice number																									
Address																									\mathbb{L}
																				C	ode				
Telephone number																									
Email address																									
General practitioner 2																									
General practitioner's name and surname																									Π
Practice number																									
Address																									
																				C	ode				
Telephone number																									
Email address																									
5. AFFIDAVIT – DETAILS OF MO	IINC	HLY	IN	CON	ИŁ																				
I declare that my monthly income is R	me is R							and consists of the following:																	
Monthly pension Investments							An	nuiti	es				Ot	ther											
If other, please specify:																									
1					-	nfirm	tha	الد	of th	o inf	0r	ation	ic te	c ;	n 01″	20.4 E	200	ct I	unda	rcta	nd ar	nd ac	ıroo	that	the
r,consequence of submitting inaccurate inform	ation	coul	d res	sult i			เมล	ı dli	UI TN	e int	υιM	au0N	i is ti	ue II	reve	ery fo	espe	ct. I	unae	เรเสิ	nd ar	ıu aç	jiee	มอเ	uie

- 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.

MEMBER NUMBER														
5. AFFIDAVIT – DETAILS OF MONTHLY IN	ICOME – CONTIN	UED												
Signed at	on the	DAY	of .				MON	TH				_		/EAR
Member's signature		Comr	nissione	r of O	aths									
DateDD/MM/YYYY														
6. DECLARATION AND AUTHORISATION	orial Matus Med and a	groe that					os of							m time
I hereby apply to continue as a pensioner member on Imp to time. Imperial Motus Med is hereby authorised to debit my bank Motus Med is authorised to continue thereafter to pay each the Imperial and Motus Medical Aid is notified of my resign	king account with the n h month such subscript	nonthly co	ntributio	ons pa	id to	the Im	nperia	l and	Moti	JS M	edica	l Aid	l. Imj	perial
I agree that should any sum due to the Scheme not be time recovery of such sums, including tracing charges and all fe	neously paid by me for es due by the Scheme	to its atto	rneys, in	cludir	ng cor	nmiss	ion.							
IMPORTANT: Should the application form be incomplete be returned for correction.	e or it the required do	cuments	are not	аттас	ned,	regist	ratioi	ı WIII	i be (delay	yed a	is th	е то	m WIII
Name of principal member														
Signature of principal member					C	ate _			DI	D/MI	M/YY	ΥΥ		