

**CONTINUATION MEMBERSHIP FOR 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 [membership@imperialmotusmed.co.za](mailto: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 DETAILS OF PRINCIPAL MEMBER (COMPULSORY TO COMPLETE)**

Member number	<input type="text"/>	Title	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>	Initials	<input type="text"/>
Identity/Passport number	<input type="text"/>		
Telephone numbers	<input type="text"/> Work	Home	<input type="text"/>
	<input type="text"/> Cell number		
Email address	<input type="text"/>		
Physical address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/> Code <input type="text"/>		

**2. BANKING DETAILS**

Please attach a copy of your ID and a bank statement or stamped letter from your bank (not older than three months).

Name of account holder	<input type="text"/>		
Account number	<input type="text"/>		
Name of bank	<input type="text"/>		
Branch name	<input type="text"/>		
Eight-digit branch code	<input type="text"/>		
Account type	<input type="checkbox"/> Current	<input type="checkbox"/> Savings	<input type="checkbox"/> Transmission <input type="checkbox"/> Cheque

Imperial Motus Med is hereby authorised to debit my banking account with the monthly contributions paid to Imperial and Motus Medical Aid.  
Please note: Contributions are paid in advance.

Signature of account holder \_\_\_\_\_

Date \_\_\_\_\_  
DD/MM/YYYY

MEMBER NUMBER

### 3. OPTION SELECTION

Please indicate which plan you prefer by ticking one of the boxes below – you may only choose one.

Imperial Motus Med Health Plan       Imperial Motus Med Budget Plan

### 4. CHOICE OF NETWORK GENERAL PRACTITIONER (ONLY APPLICABLE IF YOU CHOOSE THE BUDGET PLAN)

If you chose to be on the Imperial Motus Med Budget Plan, please provide the details of one or two general practitioners you would like to make use of:

#### General practitioner 1

General practitioner's name and surname

Practice number

Physical address   
  
 Code

Telephone number

Email address

#### General practitioner 2

General practitioner's name and surname

Practice number

Physical address   
  
 Code

Telephone number

Email address

### 5. AFFIDAVIT – DETAILS OF MONTHLY INCOME

I declare that my monthly income is  R  and consists of the following:

Monthly pension       Investments       Annuities       Other

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.

