Imperial™ Motus Med

MEMBER AND/OR DEPENDANT OVER 18 CONSENT FORM

- 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 this 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**.

Please note: The Scheme reserves the right to request additional information, if required. All personal information recorded on this form and submitted to us shall be processed by Imperial Motus Med in accordance with the law and the Scheme's **Privacy Policy**, which is available at **www.imperialmotusmed.co.za** or on request from our client service department on **0860 467 374**.

PLEASE COMPLETE IN BLOCK LETTERS.

1. SCHEME MEMBERSHIP INFORMATION

Membership number

Benefit option
- ☐ Health Plan
- ☐ Budget Plan

2. PARTICULARS OF PERSON GIVING CONSENT

Principal member and/or registered dependant over the age of 18

Full name and surname | Dependant code*

Identity/Passport number | Relationship

Contact number

Physical address

Code

Email address

Dependant code of principal member or registered dependants, if applicable

3. TO WHOM YOUR INFORMATION MAY BE DISCLOSED

Please specify the details of the appointed party to whom your information may be disclosed.

Once-off consent ☐ Yes ☐ No

Continuous consent ☐ Yes ☐ No

Time period for which consent will be valid: DD/MM/YYYY to DD/MM/YYYY

Please note: If period is not specified, the consent will be in effect from the date of the signature below and will continue thereafter indefinitely unless expressly withdrawn in writing by the applicant.

3. TO WHOM YOUR INFORMATION MAY BE DISCLOSED (CONTINUED)

Relationship to principal member or registered dependant

Full name and surname

Identity/Passport number

Date of birth DD/MM/YYYY

Contact number

Physical address

Code

Email address

4. INFORMATION THAT MAY BE DISCLOSED

Please indicate what information may be disclosed to the appointed party referred to above. Please note that only information relating to the categories you select below will be disclosed.

TYPE OF INFORMATION

- [ ] **Personal information**
  Personal details, such as your identity number, physical address and contact details, etc.
- [ ] **Scheme benefit information**
  Benefits and limits, claims history, etc.
- [ ] **Financial information**
  Banking details, claims, contributions and amounts due to the Scheme, etc.
- [ ] **Medical information**
  Personal medical history, diagnoses, treatment plans, chronic information, hospitalisations and authorisations, etc.
- [ ] **Scheme membership documents**
  Claims statements, membership and tax certificates, etc.
- [ ] **All of the above**

5. CONSENT

We request your consent to disclose your information to the appointed party mentioned on pages 1 and 2 for the purposes set out below.

While your consent is voluntary, it is a requirement for Imperial Motus Med and its Administrator, Momentum Health (Pty) Limited, a division of Momentum Group Limited, to keep your personal information confidential and to comply with the Protection of Personal Information Act 4 of 2013 (POPIA) when processing your information.

The information of members and their registered dependants will be processed for the purposes outlined in the Medical Schemes Act, 131 of 1998.

Please read the statements below and sign your acceptance thereof in the **DECLARATION** on page 3.

1. I authorise and give consent to the Scheme and its Administrator to collect, store, collate, process, share and further process my information for purposes of Scheme membership risk profiling and management, administration of membership and as set out in this section.

2. If I have consented to the disclosure of my information, the Scheme or its Administrator may provide my information to any natural or juristic person (which could include a company, corporation, state or agency of a state, association, trust or partnership) or if a contractual relationship exists between the Scheme or its Administrator that requires them to do so.

3. I acknowledge that I must give the Scheme and its Administrator all information and evidence they may require from time to time.

   I authorise the Scheme and its Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to the principal member and their registered dependants in the past, or who will attend to them in the future, any information the Scheme may require concerning the principal member and their registered dependants in assessing any risk or claim in relation to this application, their membership of the Scheme and risk profiling or management.

   I consent to that person providing, and instruct that person to provide, the Scheme and its Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.

5. CONSENT (CONTINUED)

4. I have the right to withdraw my consent to have my information disclosed, provided that the lawfulness of the processing of my information before my withdrawal will not be affected.
5. I have the right to object on reasonable grounds relating to my particular situation to disclosing my information, unless it is required by law.
6. I have the right to request my information, which is in the possession of the Scheme and its Administrator, provided that I furnish adequate identification.
7. I have the right to request the Scheme and its Administrator, where necessary, to correct or delete my information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.
8. If I have a complaint relating to the processing of my information, I agree to first refer it to the Scheme's Administrator to resolve it in terms of its internal complaints process.

   If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator on **010 023 5200** or by email at **enquiries@inforegulator.org.za**.
9. My information will be shared between the Scheme, its Administrator and any of their contracted third parties who require this information for purposes related to membership of the Scheme.

6. DECLARATION

I, the undersigned, hereby:

- authorise Imperial Motus Med and its Administrator to disclose the above information to the appointed party, as indicated on pages 1 and 2
- agree that neither Imperial Motus Med nor its Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure of my information pursuant to this consent
- agree that once consent is provided, all my information, as indicated herein, may be disclosed to the appointed party.

I declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Name of person/entity/appointed party giving consent			
Signature of person/entity/appointed party giving consent		**Date**	DD/MM/YYYY

11/2025