ADULT CHILD/GRANDCHILD APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE
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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

***Please complete in block letters, tick appropriate blocks unless otherwise indicated**

Botswana has implemented a law known as the Financial Intelligence Act and its Regulations, to combat money laundering (and other financial crimes), which is the abuse of financial systems to hide and/or disguise the proceeds of crime. In terms of this Act and its Regulations, BPOMAS is required before establishing a business relationship or carrying out a transaction, to obtain and verify, at a minimum, a prospective customer's identity, address and source of funds.Please play your part as a member to assist us in complying with these customer due diligence obligations by completing this form and submitting the attachments listed below.

Requirements
- Form must be signed and stamped by your employer
- Form to be completed by Applicant

Attachments
- Copy of certified birth certificate for Adult Child/Grandchild
- Copy of Adult Child omang (If adding Adult Child)
- Sworn affidavit if adding Grandchild
- Recent payslip
- Certificate of membership from previous medical aid (if any)

SECTION 1: RULE EXTRACTS OF INDIVIDUAL MEMBERSHIP

1. Adult Child refers to person(s) aged between 21 and 35years, who is not in receipt of income not more than the minimum wage from the Government of Botswana and should have been a member of BPOMAS for a continuous period of one (1) year.
2. A grandchild dependant who is under the age of twenty-one (21) years, who is unmarried and who is not in receipt of regular remuneration.

*The above will only be eligible for membership to an already existing BPOMAS member whose monthly contributions are fully paid up and up to date.

SECTION 2: DEPENDANT BEING APPLIED FOR

Please tick one:

Adult Child ☐ Grandchild ☐

SECTION 3: TYPE OF MEMBERSHIP

Standard Benefit **Up to P30, 000 Cover** ☐	High Benefit **P315, 000 Cover** ☐	Premium Benefit **P500, 000 Cover** ☐
• No 10% Co-Payment	• 10% Co-Payment	• 10% Co-Payment
• Limited Hospitalisation Cover	• Comprehensive Hospitalisation Cover	• Comprehensive Hospitalisation Cover
• No Chronic and Dread Disease Cover	• Chronic and Dread Disease Cover	• Chronic and Dread Disease Cover
• P5, 000 Funeral Benefit Cover	• P10, 000 Funeral Benefit Cover	• P12, 500 Funeral Benefit Cover
• 24Hr Emergency Medical Services	• 24Hr Emergency Medical Services	• 24Hr Emergency Medical Services
• Premium Waiver (6months)	• Premium Waiver (6months)	• Premium Waiver (6months)
• 24Hr Mental Health Assistance	• 24Hr Mental Health Assistance	• 24Hr Mental Health Assistance
	• Wellness Benefit	• Wellness Benefit

SECTION 4: DETAILS OF THE PRINCIPAL MEMBER

Membership Number _____ ID or Passport Number _____

Email _____ Cellphone Number _____

Postal Address _____

SECTION 5: DETAILS OF THE ADULT CHILD DEPENDANT (To be completed by Adult child)

Title ☐ Initials ☐ Surname _____ ID/Passport ☐☐☐☐☐☐☐☐☐☐☐

First Name(s) _____ Sex M ☐ F ☐

Relationship _____ Date of Birth ☐☐☐☐☐☐☐☐

Cell ☐☐☐☐☐☐☐☐ Tel (H) ☐☐☐☐☐☐☐ Tel (W) ☐☐☐☐☐☐☐

Email _____

Postal Address	
Physical Address	

SECTION 6: DETAILS OF THE GRANDCHILD DEPENDANT (only complete if adding Grandchild)

Title | Initials | Surname | ID/Passport

First Name(s)

Relationship | Date of Birth

Cell | Tel (H) | Tel (W) | Fax

Email

Postal Address	
Physical Address	

SECTION 7: EMPLOYER WARRANTY

Name

Designation

Telephone

Employer's Stamp

Authorised Signatory

SECTION 8: MEDICAL AID HISTORY OF THE ADULT CHILD/GRANDCHILD DEPENDANT

Name of Previous Medical Scheme/s	Date Joined	Date Left

SECTION 9: BANK DETAILS OF APPLICANT

Please note: we can not accept credit card account details

Bank Name | Branch Name

Branch Code | Account Number

Account Type | Current | Savings | Account Holder

CONTRIBUTION TABLE

Membership Category	Standard (P)	High (P)	Premium (P)
Grandchild under 21 years	158	291	571
Adult Child between 21-30 years	340	535	800
Adult Child 31-35 years	351	677	1145

SECTION 10: MEDICAL HISTORY & GENERAL HEALTH INFORMATION OF THE ADULT CHILD/GRANDCHILD DEPENDANT

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

OPTIONAL DISCLOSURE

With specific reference to and acknowledgement of the details contained in the Medical Details below, failure to disclose the chronic and dread disease or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion.

(please supply the required information by marking the relevant box with an **X**)

1.	Do you or the Grandchild use Chronic Medicine?	Yes	No
2.	Disorders or problems with heart or cadiovascular system, e.g heart murmur, high blood pressure, high cholestrol, shortness of breath, palpitations, chest pains, angina, heart attack and/or other cardiac or blood disoders.	Yes	No
3.	Respiratory or lung disorders, e.g tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitus or allergic rhinitis.	Yes	No
4.	Disorders in the digestive system, stomach, gall bladder, pancrease or liver, e.g gastric or duodenal ulcers, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure or have you ever had a gastroscopy or colonoscopy?	Yes	No
5.	Diseases or disorders of the kidneys, bladder or reproductive organs, e.g abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted diseases.	Yes	No
6.	Disorder of the nervous system or brain, e.g epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have you or any of your dependants been advised to have an MRI or CT scan?	Yes	No
7.	Mental disorders, e.g depression, anxiety, panic attack, schizophrenia, eating disorders, attention deficit hyperactive disorder (ADHD), or post -traumatic stress disorder.	Yes	No
8.	Ear, nose, throat or eye disorders, eg defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies.	Yes	No
9.	Disorders or diseases of the skin, muscles, bones, joints, limbs or spine, e.g any skin rash, arthritis, gout, fibromyalgia, any back, neck, hip, knee or other joint trouble, multiple sclerosis, any joint problems, or replacements, acne, eczema or psoriasis?	Yes	No
10.	Diabetes, thyroid or other glandular or blood disorders, e.g anaemia bleeding disorders, growth disorder, cushing's disease or Addison's disease.	Yes	No
11.	Cancer, a growth or tumor of any kind including moles removed (malignant/benign).	Yes	No
12.	Are you or the Grandchild currently undergoing or anticipating any specialised dental, maxillofacial treatment?	Yes	No
13.	Have you or the Grandchild had any accidents (including motor vehicle accidents)? If yes; confirm injuries sustained in accident and if there is any temporary or permanent injuries, and if you require any current of future treatment.	Yes	No
14.	Are you or the Grandchild taking ongoing medicine for any condition no listed in any other of the questions?	Yes	No
15.	Have you or the Grandchild had any surgical procedure?	Yes	No
16.	Is the Grandchild awaiting or planning any operation or admission to any hospital in the next 12 months?	Yes	No
17.	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months?	Yes	No
18.	Gynaecological disorders, e.g abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormalities of pregnancy.	Yes	No
19.	Are you or any of the Grandchild pregnant? If so, what is the expected date of delivery? Date: _____	Yes	No

DISCLAIMER

Please note that the following exclusions and waiting periods may be applicable as prescribed by the Scheme:

- 2 years for pre-existing Chronic Medical Condition(s),
- 1 year for limited Dentistry,
- 9 months for maternity and
- 3 months for an infant child registered after 30 days of birth or adoption.

If your answer was yes to any of the above questions, please provide full particulars in the next page. Please use a separate sheet of paper if the space provided is not enough.

Name of Person suffering from the Illness	Question Number	Name of the Condition	Date Diagnosed	Name of Medication	Date of Last Treatment / Medication	Date of Last Symptoms	Attending Doctor

SECTION 11: NOMINATION OF FUNERAL BENEFIT PAYOUT

In the event that the Dependant member passes on, the person named below will be legible to claim for the funeral benefit payout.

Surname

Name

ID Number

Contacts

Address

Relation

SECTION 12: DECLARATION

Failure to disclose material information is fraud. The provision of false, incorrect or incomplete information can result in the immediate cancellation of your membership.

Failure to disclose material information is fraud. The provision of false, incorrect or incomplete information can result in the immediate cancellation of your membership.

I the undersigned, hereby make application to the Administrator to be admitted as a member of the Scheme, and I agree to abide by the Rules of the Scheme. I declare that any false statement in the above questionnaire or the non-disclosure of any material information will render my membership null and void. I warrant that the above answers are true, correct and complete in every respect. I hereby authorise my employer to deduct from my salary each month the specified contribution and indebtedness to the Scheme and pay the Scheme on my behalf. I confirm that I am employed by the Employer in a full time capacity. I undertake to advise BPOMAS and its Administrator of any change in my state of health or that of my dependants which occurs prior to my receiving written acceptance of this application.

In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission, dissemination of such information in line with the Scheme services.

Signature of Member:_____ Date:_____

SECTION 13: BPOMAS COMMITMENT

The Scheme is committed to ensuring compliance with the Data Protection Laws of Botswana and that the information collected is used only for the purpose intended.

SECTION 14: CONSENT TO RECEIVE SCHEME UPDATES & MARKETING MATERIAL

I consent to receive Scheme updates and Marketing BPOMAS products, benefits, promotions and rewards. This can be perfomed through:

Email ☐ SMS ☐ Phone ☐ Postal Adress ☐

Signature of Member:_____ Date:_____

SECTION 15: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

Data protection is a matter of trust and your trust is important to us. We respect your right to confidentiality and privacy and, we are committed to complying with the Data Protection Act. The protection and the lawful collection, processing and use of your personal data is therefore an important concern for us in the provision of our services to our members.

SECTION 16: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

16.1 Acknowledgement

I hereby expressly acknowledge that the processing off my Personal Information and/or Special Personal Informantion by BPOMAS ("collectively referred to as "Personal Information"), as defined in terms of the Data Protection Act of 2018 (DPA). I acknowledge that;

16.1.1 I have read and understood the provisions of BPOMAS's Data Protection and Privacy Statement, thereby fully appreciating the manner in which BPOMAS may process my Personal Information and for which purpose(s) BPOMAS may process such Personal Information.

16.1.2. Through submitting this application, I am providing BPOMAS with my Personal Information and that engaging with BPOMAS through any physical and/or electronic means, BPOMAS will in effect be processing the Personal Information provided by me from time to time.

16.1.3 BPOMAS may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.

16.1.4 I fully appreciate that BPOMAS will only process my Personal Information in a manner consistent with the provisions of its Data Protection Act, as well as for the purpose(s) set forth therein.

16.1.5 In accordance with the provisions of Section 28 of DPA, I have been provided with adequate notification of the processing of my Personal Information by BPOMAS, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so, and to request for access/destruction of my Personal Information that is held by BPOMAS.

16.1.6 I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

16.1.7 I have read and understood the undertakings made by BPOMAS in its Data Protection and Statement to the effect that it will ensure that any and all of personal Information shall be processed with a reasonable standard of care as may be expected from BPOMAS.

16.2 Consent

In light of the above acknowledgements, and in accordance with the requirements set forth in Section 20 of Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:

16.2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.

16.2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the BPOMAS.

16.2.3 To facilitate the delivery of products and/or services to me as a member of BPOMAS to administer my claims and premiums.

16.2.4 To activate my medical aid and/or prescribed benefits to allocate a unique identifier (membership number) to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.

16.2.5 To transact with suppliers and business partners, including healthcare service providers, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.

16.2.6 To provide me with health and wellness information throughout the subsistence of my membership.

16.2.7 To transact with third parties and transfer my Personal Information (locally or across border) to such third parties for the purpose of enabling BPOMAS to fulfil its legitimate pursuit of contractual obligations towards me and within the requirements of the Data Protection Act.

16.2.8 To analyse and profile my Personal Information collected for research and statistical purposes.

16.2.9 For general administration purposes pertaining to my membership.

Signature of Member: _____ Date: _____

SECTION 17: ADULT CHILD/GRANDCHILD DEPENDANT APPLICATION FORM CHECKLIST

NB: Members will be subjected to sanctions Screenings and Anti-Money Laundering/Combatting Financing of Terrorism & Proliferation (AML/CFT &P) control measures as required by applicable legislations .

	Yes	No
Certified Copy of Adult Child/Grandchild ID	☐	☐
Certified Copy of Adult Child/Grandchild Birth Certificate	☐	☐
Copy of the Member's Payslip	☐	☐
Adult Child/Grandchild's Certificate of Previous Medical Aid Cover (if any)	☐	☐
Duly Completed Sworn Affidavit (Only applicable to Grandchild Dependant)	☐	☐