CHANGE OF BENEFIT OPTION

BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME Administered by Associated Fund Administrators Botswana (Pty) Ltd.
Gaborone: AFA House • Plot 61918 • P O Box 1212 • Gaborone • Botswana • Telephone: (+267) 365 0555 (Call center) / 365 0500 (Reception) • Fax: (+267) 395 1165
Francistown Branch: Baines Avenue • Plot 31966 • Unit 2 • Ground Floor • P O Box 323 • Francistown • Botswana • Telephone: (+267) 241 2390 / 241 2290 • Fax: (+267) 241 2340
www.bpomas.co.bw

BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME
Your health is our concern!

***please complete in block letters, tick appropriate blocks unless otherwise indicated**
***please select an option you want to upgrade/degrade to:**

PREMIUM P500,000 Cover ☐ **HIGH** P300,000 Cover ☐ **STANDARD** UP to P30,000 Cover ☐

About yourself (principal member)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname

First name(s) Sex M ☐ F ☐ Date of birth d d m m y y y y

Occupation

Membership Number ID or Passport Number

Basic Salary P Country of Issue

Cell Tel (H) Tel (W) Fax

Email

Postal Address Village/Town Physical Address

Note* Member may only transfer from one benefit to the other on the first day of the financial year provided he has given one(1) month written notice.

Your employment details

Name of Employer

Occupation Date of employment d d m m y y y y

Employer warranty

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.
Botswana Public Officers' Medical Aid Scheme may bill us for the amount due for this member in the same way as it does for our other employees with Botswana Public Officers' Medical Aid Scheme (BPOMAS).

Name

Designation

Email

Telephone

Postal Address

EMPLOYER'S STAMP

Authorised signatory_____ Signature of the Principal Member:_____

Your banking details

Please note: we can not accept credit card account details

Bank name

Branch name | Branch code

Account number | Type of account Cheque ☐ Savings ☐

Account holder

By signing this application, you agree that claims will be refunded into the account you have chosen.

Signature of the Principal Member:_____

***please attach a clear copy of your recent payslip (not older than two months)**

Nomination for funeral benefit payout

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

Surname

Name

ID number

Contacts

Address

Relation