NEW MEMBER APPLICATION FORM

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
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www.bpomas.co.bw **Botswana Public Officers' Medical Aid Scheme**

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

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

Choose Option: **PREMIUM** P500,000 Cover ☐ **HIGH** P300,000 Cover ☐ **STANDARD** 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

ID or passport number Country of Issue
***attach a copy of ID**

Basic Salary P ***Attach copy of recent payslip (not older than 2 months)**

Cell Tel (H) Tel (W) Fax

Email

Postal Address Village/Town Physical Address

About your spouse (only complete if adding spouse)

Title ☐ Initials ☐ Surname

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

Employer

ID or passport number Country of issue

Cell Tel (H) Tel (W)

Email

***attach copies of marriage certificate and spouse ID**

About your dependants (*only complete if adding child dependants)

FAMILY MEMBERS TO BE COVERED

First Names & Surname(s) ***Attach child's birth certificate**	Birth Dates D D M M Y Y Y Y	Gender	Identity Number/Birth Certificate or Passport Number

Date of commencement of employment

Date of joining the Scheme

Name of previous Medical Scheme

Date of previous membership From: To:

***if any, attach certificate of Membership**

IMPORTANT
Failure to complete all information and attached document required **will** delay processing of membership. Failure to disclose material information or provision of incorrect information **can** result in the immediate cancellation of membership.

Your employment details

Name of Employer

Department

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:_____

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)**
***please attach proof of account (cancelled cheque/bank statement)**

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

*** please complete the Medical History and General Health infomation form**