CHANGE OF BENEFIT OPTION FORM

ADMINISTRATORS OFFICE GABORONE

Plot 54349, Ground Floor, West Wing,
The Field Precinct, CBD
Premium Box 625 AAH, Gaborone
Tel: +267 316 8900
Fax: +267 316 8910

ADMINISTRATORS OFFICE FRANCISTOWN

Plot 44149 MVA Fund Building, 3rd Floor
Tel: +267 316 8902
Fax: +267 316 8910

bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

Requirements

- Form must be signed and stamped by your employer
- Member can 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

Attachments

- Recent payslip (not older than 3 months)

SECTION 1: SELECT YOUR HEALTH PLAN

Please select an option you like to Upgrade/Downgrade to

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 2: ABOUT YOURSELF (PRINCIPAL MEMBER)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname ☐

First Name(s) ☐

Membership Number ☐ ID or Passport Number ☐

Email ☐ Cellphone Number ☐

Postal Address ☐

SECTION 3: YOUR EMPLOYMENT DETAILS

Name of Employer ☐

Occupation ☐ Date of Employment d d m m y y y y

Basic Salary P ☐

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 ☐

Authorised signatory: _____

EMPLOYER'S STAMP

SECTION 4: 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 5: 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 6: 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 7: 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 8: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

8.1 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;

8.1.1 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.

8.1.2. 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.

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

8.1.4 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.

8.1.5 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.

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

8.1.7 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.

8.2 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:

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

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

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

8.2.4 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.

8.2.5 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.

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

8.2.7 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.

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

8.2.9 For general administration purposes pertaining to my membership.

Signature of Member: _____ Date: _____

SECTION 9: CHANGE OF BENEFIT OPTION 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
Copy of Payslip	☐	☐