

# TERMINATION FORM



**BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME** Administered by Associated Fund Administrators Botswana (Pty) Ltd.  
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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**

Person(s) being terminated: **Principal Member**  **Dependant**

## About yourself (principal member)

Marital Status: Married  Single  Divorced  Widowed

Title  Initials  Surname

First name(s)  Sex M  F  Date of birth

Occupation

Membership Number

Cell           Tel (H)           Tel (W)           Fax

Email

Postal Address  Village/Town  Physical Address

## DETAILS OF PERSON(S) BEING TERMINATED OR WITHDRAWN

First Names & Surname(s)	Relationship to member	Birth Dates								Gender	Identity Number/Birth Certificate or Passport Number
		D	D	M	M	Y	Y	Y	Y		

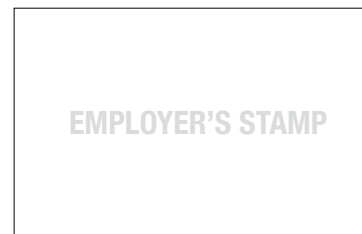
## REASONS FOR TERMINATION (Tick where applicable)

- 1. Financial Constraints
- 2. Joining Spouse Cover
- 3. Joining New Medical AID
- 4. Resigned/Change of Employer
- 5. Divorced
- 6. Deceased
- 7. Other   
 please specify: \_\_\_\_\_

Employer Signature \_\_\_\_\_

Signature of the Principal Member: \_\_\_\_\_

Date \_\_\_\_\_



- 1. We require 1 month's notice before termination can be effected.
- 2. Voluntary termination leads to a member not being accepted back into the scheme for a period of 24 months.
- 3. Please further note that your benefits will be prorated up to the date of termination.