PARENT DEPENDANT APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE

Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
Premium Box 625 AAH, Gaborone
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ADMINISTRATORS OFFICE FRANCISTOWN

Plot 32397, Office 26, Sunshine Plaza
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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

Requirements

- Complete the Parent Dependant form
- Have it signed and stamped by your employer
- Duly completed Medical Report
- Duly completed Sworn Affidavit report

Attachments

- Copy of certified parent ID
- Recent payslip (not older than 2 months)
- Certificate of membership from previous medical aid (if any)

SECTION 1 - RULE EXTRACTS OF INDIVIDUAL MEMBERSHIP

1. Parent Dependant refers to the Principal member's biological/adoptive mother or father and/or the biological/adoptive mother or father of the spouse who is not a pensioner
2. The maximum entry age is 65 years for Parent Dependant
3. A medical report not more than a month old is required for Parent Dependant
4. A 3 month waiting period shall apply to the Parent Dependant

*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 - TYPE OF MEMBERSHIP

Standard Benefit **Up to P30,000 Cover** ☐	High Benefit **P300,000 cover** ☐
• No 10% Co-payment	• 10% Co-payment
• No hospitalization	• Hospitalization cover
• No chronic and dread disease cover	• Chronic & dread disease cover
• P5, 000 Funeral benefit cover	• P10, 000 Funeral benefit cover
• 24Hr Emergency medical services	• 24Hr Emergency medical services
• Premium waiver (6months)	• Premium waiver (6months)

SECTION 3 - DETAILS OF THE PRINCIPAL MEMBER

Title ☐ Initials ☐ Surname

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

Occupation Payroll number

ID or passport number Country of Issue

Email

Cell Tel (H) Tel (W) Fax

SECTION 4 - DETAILS OF THE PARENT DEPENDANT

Title ☐ Initials ☐ Surname ID/Passport

First name(s) Sex M ☐ F ☐

Relationship Date of Birth

Cell Tel (H) Tel (W) Fax

Email

Postal Address	
Physical Address	

SECTION 5 - PRIMARY CONTACT: PRINCIPAL ☐ APPLICANT ☐

Date of joining the scheme _____ Name of the previous scheme _____

Date of the previous membership; From _____ To _____

Declaration: I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform The Scheme of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Date _____ Signature _____

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

SECTION 6 - EMPLOYER WARRANTY

Name _____

Designation _____

Telephone _____

Authorised Signatory _____

Employer's Stamp

SECTION 7 - MEDICAL AID HISTORY OF THE PARENT DEPENDANT

Name of previous medical scheme/s	Medical aid number	Date joined	Date left

SECTION 8 - BANK DETAILS OF PRINCIPAL MEMBER (EMPLOYEE)

Please note: we can not accept credit card account details

Bank name _____ Branch name _____

Branch code _____ Account number _____

Type of account Current ☐ Savings ☐ Basic Salary **P** _____

Account holder _____

CONTRIBUTION TABLE

Membership category	Standard (P)	High (P)	Premium (P)
Parent Dependant	386	1524	N/A

LATE JOINER PENALTY

Any applicant who is fifty (50) years of age or older who was not a member of one or more medical schemes at the time of joining the Scheme will incure a penalty by way of additional contributions as per Scheme rules as follows;

Years member was not a member of medical aid since the age of 50	Late joiner penalty
1-4 years	1.25
5-14 years	**1.5**
15-24 years	1.75
25 years +	**2**

SECTION 9 - MEDICAL HISTORY & GENERAL HEALTH INFORMATION OF THE PARENT 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 any of your dependants 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 abnomal 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 any of your dependants currently undergoing or anticipating any specialised dental, maxillofacial treatment?	Yes	No
13.	Have you or any of your dependants had any accidents (including motor vehicle accidents)?	Yes	No
14.	Are you or any of your dependants taking ongoing medicine for any condition no listed in any other question?	Yes	No
15.	Have you or any of your dependants had any surgical procedure?	Yes	No
16.	Are you or any of your dependants 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.	Gynecological 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 your dependants 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 the person suffering from the illness				
Question number				
Illness or condition				
Date on which illness began				
Date of last occurance				
Name of treating Doctor				
Doctor's contact details				
Treatment recommended (medicine, etc.)				
Treatment from (date)				
Treatment until (date)				

SECTION 10- BRAND KNOWLEDGE

How did you hear about us? Newspaper ☐ Internet ☐ Radio ☐ Television ☐ Other _____

How would you like us to communicate with you? Sms ☐ Email ☐ Postal ☐

SECTION 11- NOMINATION OF FUNERAL BENEFIT PAY-OUT

In the event that the Parent 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.

I the undersigned, hereby make application to the Administrator to be admitted as a member of the Scheme, and if admitted 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 the 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 - PARENT DEPENDANT APPLICATION FORM CHECKLIST

NB: Members will be subjected to sanctions Screening and Anti-Money Laundering/Combatting Financing of Terrorism & Proliferation (AML/CFT &P) due diligence measures.

	Yes	No	N/A	Comments
Certified copy of the Parent ID	☐	☐	☐	
Sworn affidavit or Certified copy of members birth certificate	☐	☐	☐	
Copy of the principal member's payslip	☐	☐	☐	
One month valid medical report	☐	☐	☐	

MEDICAL REPORT FORM

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SECTION 1 - APPLICANT DETAILS

Name	
Gender	
Date of Birth	
ID Number	
Mobile Number	
E-mail address	

SECTION 2 - GENERAL EXAMINATION

Height _____ Weight _____

BP _____ Resp Rate _____

General Appearance: _____

SECTION 3 - PAST MEDICAL HISTORY

Problem 1: _____

Problem 2: _____

Problem 3: _____

Medication and doses _____

Medication and doses _____

Medication and doses _____

Medication and doses _____

	Examination findings	Normal	Abnormal	If abnormal comment
Eyes	Conjuctivae & Lids	☐	☐	_____
	Pupils & Irise			_____

	Examination findings	Normal	Abnormal	If abnormal comment
Ear, Nose, Mouth & Throat	External Inspection	☐	☐	
	Otoscopic exam			
	External Auditory Canal	☐	☐	
	Tympanic Membranes	☐	☐	
	Hearing Assesmen	☐	☐	
	Nasal Mucosa, Septum & Turbinales	☐	☐	
	Lips, Teeth & Gums	☐	☐	
	Oropharynx	☐	☐	
	Oral Mucosa, Salivary Glands			
	Hard/Soft Palates, Tongue			
	Tonsil & Posterior Pharynx			
Neck	Neck. Tracheal Position	☐	☐	
	Thyroid	☐	☐	
Respiratory	Respiratory Effort	☐	☐	
	Percussion of Chest	☐	☐	
	Palpation of Chest	☐	☐	
	Auscultation of Lungs	☐	☐	
Abdo	Inspection	☐	☐	
	Palpation	☐	☐	
	Auscultation	☐	☐	
Cardiovascular	Palpation of Heart	☐	☐	
	Ausulation of Heart	☐	☐	
CNS	Mental Status	☐	☐	
	Muscle Strength	☐	☐	
	Tone	☐	☐	
	Sensory Function	☐	☐	

SECTION 4 - SUMMARY OF FINDINGS

Name of Medical Practitioner: _____

Signature: _____

Practice Name/ Clinic/Hospital: _____

Contact Details

Email: _____

Tel: _____

Cell: _____

Doctor/Practice stamp

SWORN AFFIDAVIT

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I _____ of ID no _____ and address (residential and postal) _____ do hereby solemly declare that _____ of ID no _____ and address (residential and postal) _____ is my biological mother/father/mother in law/father in law. I accept full responsibility for notifying the Scheme in writing if there are any changes pertaining to this relationship.

I declare that I am responsible for his/her essential needs such as food, clothing and health. I agree to provide any supporting documentation as may be required from time to time in support of this affidavit.

I recognize that this affidavit is a legally binding document. I understand that it would be unlawful to knowingly make or cause to be made any false material statement or material representation, omit to disclose a material fact or to otherwise provide false information with the intent to use it or allow it to be used to obtain, receive or continue to receive, increase or deny or reduce any benefit offered by the Scheme.

I understand the contents of this declaration and have no objection to taking the prescribed oath.

I declare that all the information given above is true, correct, and binding on my conscience.

_____
Deponent

Sworn before me on _____ day of _____ at _____(place) _____ (time).

_____
Commissioner of Oaths (name)

_____
Commissioner of Oaths (signature)

Stamp