

PARENT DEPENDANT APPLICATION 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 32397, Office 26, Sunshine Plaza
Tel: +267 316 8902
Fax: +267 316 8910



BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

Requirements

- Complete the Parent Dependiant 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 Dependiant 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 Dependiant
3. A medical report not more than a month old is required for Parent Dependiant
4. A 3 month waiting period shall apply to the Parent Dependiant

*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

- No 10% Co-payment
- No hospitalization
- No chronic and dread disease cover
- P5, 000 Funeral benefit cover
- 24Hr Emergency medical services
- Premium waiver (6months)

High Benefit
P300,000 cover

- 10% Co-payment
- Hospitalization cover
- Chronic & dread disease cover
- P10, 000 Funeral benefit cover
- 24Hr Emergency medical services
- Premium waiver (6months)

SECTION 3 - DETAILS OF THE PRINCIPAL MEMBER

Title Initials Surname

First name(s) Sex M F Date of Birth

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	<input type="text"/>
Physical Address	<input type="text"/>

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.

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.

Date _____ Signature _____

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 incur 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 cardiovascular system, e.g heart murmur, high blood pressure, high cholesterol, shortness of breath, palpitations, chest pains, angina, heart attack and/or other cardiac or blood disorders.	Yes	No
3.	Respiratory or lung disorders, e.g tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis.	Yes	No
4.	Disorders in the digestive system, stomach, gall bladder, pancreas 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 abnormal 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 not 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 occurrence				
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	N/A	Comments
Sworn affidavit or Certified copy of members birth certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	N/A	Comments
Copy of the principal member's payslip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	N/A	Comments
One month valid medical report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____

Medication and doses _____

Medication and doses _____

Problem 2: _____

Medication and doses _____

Medication and doses _____

Problem 3: _____

Medication and doses _____

Medication and doses _____

Medication and doses _____

	Examination findings	Normal		Abnormal		If abnormal comment
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	Conjunctivae & Lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Pupils & Iris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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 solemnly
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)

