

ADULT - CHILD/PARENTS MEMBER APPLICATION



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
 Francistown Branch: Baines Avenue • Plot 31966 • Unit 2 • Ground Floor • P O Box 323 • Francistown • Botswana • Telephone: (+267) 241 2390 / 241 2290 • Fax: (+267) 241 2340
 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**

Type of Membership: ADULT - CHILD PARENT
Choose Option: STANDARD HIGH PREMIUM
P30,000 Cover P300,000 Cover P500,000 Cover

Principal Member (the employee)

Medical Aid Number:

Title Initials Surname

First name(s)

Cell Tel (H) Tel (W) Fax

Email

Postal Address Village/Town Physical Address

The Applicant (adult child/parent)

Title Initials Surname ID/Passport

First name(s) Sex M F *** attach copy of ID/Passport**

Relationship Date of birth

Cell Tel (H) Tel (W) Fax

Email

Postal Address Village/Town Physical Address

Primary contact; Principal or the Applicant

Date of joining the scheme Name of the previous scheme

Date of the previous membership; From To ***if any attach certificate of the previous membership**

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 _____

Employer Warranty

Name

Designation

Telephone

Authorised Signatory _____

Employer's Stamp

Your banking details (the employee)

Please note: we can not accept credit card account details

Bank name	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/>
Account number	<input type="text"/>	Type of account	Cheque <input type="checkbox"/> Savings <input type="checkbox"/>
Account holder	<input type="text"/>		

By signing this application, you agree that claims will be refunded into the account you have chosen.

Signature of the Employee: _____

***please attach a clear copy of your recent payslip (not older than two months)**

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	<input type="text"/>
Name	<input type="text"/>
ID number	<input type="text"/>
Contacts	<input type="text"/>
Address	<input type="text"/>
Relation	<input type="text"/>

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

Rule Extracts of Individual Membership

1. Adult Child refers to person(s) aged between 21 and 35years, who is not in receipt of income not more than the minimum wage from the Government of Botswana
2. An Adult Child should have been a member of BPOMAS for a continuous period of one (1) year, and should not be more than three (3) months not active to be eligible.
3. Parent Dependant refers to a member (the employee)s' biological/adoptive mother or father and/or the biological/adoptive mother or father of a spouse who is not a pensioner
4. The maximum entry age is 65years for parent dependant
5. A medical report not more than a month old is required for Parent Dependant
6. 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.*

New Individual Membership

Membership category	Standard (P)	High (P)	Premium (P)
Adult child dependents (21-30 years)	229	357	491
Adult child dependents (31-35 years)	236	452	703
Parent Dependent	296	1180	N/A

MEDICAL HISTORY AND GENERAL HEALTH INFORMATION

-Individual Membership



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First Name Surname ID/Passport No:

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

OPTIONAL DISCLOSURE

Although you are not obliged to disclose the Chronic/HIV AIDS status of yourself or your dependant(s) on this form, you are required, in line with the Scheme rules and underwriting criteria, to submit this form within 2 working days from the date you submit your membership application to BPOMAS health@afa.co.bw or hand deliver at AFA House, Plot 61918, Showgrounds Office Park. We want to assure you that we treat this information with the strictest of confidence.

(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, sugar in urine, 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 dependant 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.	Gynaecological 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 rules, 2 years for pre-existing 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 space below. 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)	

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 dependents which occurs prior to my receiving written acceptance of this application.

Signature of Member: _____

Date: _____

MEDICAL REPORT FORM



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Applicant Details

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

General Examination

Height _____

Weight _____

BP _____

Pulse _____

Resp Rate _____

General Appearance: _____

Past Medical History

Problem 1: _____ Medication and doses _____

Problem 2: _____ Medication and doses _____

Problem 3: _____ Medication and doses _____

Eyes	Examination findings	Normal	Abnormal	If abnormal comment
	Conjunctivae & Lids	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils & Iris	<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 Assesment	<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"/>	_____
Neck	Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Oral Mucosa, Salivary Glands Hard/Soft Palates, Tongue Tonsil & Posterior Pharynx			
	Neck, Tracheal Position	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
	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"/>	_____
Abdo	Auscultation of Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Inspection	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Palpation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Palpation of Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
CNS	Ausulation of Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
	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"/>	_____

Summary of findings

Dr. Name: _____

Signature: _____

Practice name/ Clinic/Hospital: _____

Contact Details

Email: _____

Tel: _____

Cell: _____

Doctor/Practice
Stamp



SWORN AFFIDAVIT

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 this _____ day of _____ 2019 at _____ (place), _____ (time).

Commissioner of Oaths (name)

Commissioner of Oaths (signature)

