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**

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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** P30,000 Cover ☐ **HIGH** P300,000 Cover ☐ **PREMIUM** 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 d d m m y y y y

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.

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.

Employer Warranty

Name

Designation

Telephone

Employer's Stamp

Authorised Signatory _____

Your banking details (the employee)

Please note: we can not accept credit card account details

Bank name

Branch name | Branch code

Account number | Type of account Cheque ☐ Savings ☐

Account holder

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

Name

ID number

Contacts

Address

Relation

*** please complete the Medical History and General Health infomation 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 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 sextually 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 occurance	
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 _____

	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 Assesment	☐	☐	
	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	☐	☐	

Summary of findings

Dr. Name: _____

Signature: _____

Practice name/ Clinic/Hospital: _____

Contact Details

Email: _____

Tel: _____

Cell: _____

Doctor/Practice Stamp

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SWORN AFFIDAVIT

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 this _____ day of _____ 20___ at _____(place), _____ (time).

_____
Commissioner of Oaths (name)

_____
Commissioner of Oaths (signature)

Stamp