# BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

Administered by Associated Fund Administrators Botswana ( Pty) Ltd.

**Gaborone:** AFA House • Plot 61918 • Showgrounds Office Park • 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**


## APPLICATION FORM

### SECTION 1 EMPLOYER DETAILS (Please complete with black pen and bold)

Name of the Ministry / Department at which the applicant is employed _____ Phone _____

### SECTION 2 CHOICE OF OPTION

**Choose ONE product by placing an "x" in the appropriate box** ☐ PREMIUM BENEFIT OPTION ☐ HIGH BENEFIT OPTION ☐ STANDARD BENEFIT OPTION

### SECTION 3 PRINCIPAL MEMBER DETAILS

**Place an "x" in the appropriate box**

**TITLE** ☐ MR ☐ MRS ☐ MS ☐ DR ☐ OTHER ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

Initials _____ Surname _____

First names _____ Telephone (work) _____

Occupation _____ Telephone (home) _____

Cell No _____ Fax Number _____

Email address _____

Postal Address _____

Nationality _____ Date of Birth D D M M Y Y Gender/Sex M F

ID No. (locals) Pass No. (Non citizen) _____ Payroll No. _____
Attach copy of ID
Monthly Salary (Yourself) P _____
Attach copy of advice slip

Your Spouse (if shown as a dependant below) P _____

### SECTION 4 BANK DETAILS

Bank _____ Branch _____ Account Type: Current or savings _____ Account Number _____

(Attach Bank Statement)

### SECTION 5 FAMILY MEMBERS TO BE COVERED

| First Names & Surname(s) Attach copies of marriage certificate & child's birth certificate | Birth Dates D D M M Y Y | RELATIONSHIP Husband | Wife | Daughter | Son | Nat. ID / Passport Number (For persons over 16 years) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Date of commencement of employment _____

Date of joining the scheme _____

Name of previous Medical Scheme _____

Please state pevious membership number _____

Date of previous membership: From _____ to: _____
(if any, attach certificate).

**IMPORTANT:**

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

Signature of Member: _____

Employer's date stamp: _____

Signature of Employer: _____

**PLEASE COMPLETE REVERSE**

- NB: Funeral cover does not apply to member / dependant who join after the age of 65 years

# APPLICATION FORM (CONT.)

## SECTION 6 MEDICAL HISTORY

Please give the name and address of the doctor or dentist you have consulted most recently.

Doctor: _____

Dentist: _____

| All questions must be answered "YES" or "NO" by placing a circle in the applicable. | A Principal Member | B 1st Dependant (Spouse) | C 2nd Dependant (Child) | D 3rd Dependant (Child) | E 4th Dependant (Child) | F 5th Dependant (Child) | G 6th Dependant (Child) | H 7th Dependant (Child) |
|---|---|---|---|---|---|---|---|---|
| 6.1 Have you or your dependants ever been excluded from benefit by any insurance or medical aid scheme? | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |
| 6.2 Have you or your dependants received any medical or orthodontical treatment during the last two years? (Please give dates) | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |
| 6.3 Are you or your dependants suffering from, or have you ever suffered from any chronic or recurring illness or any serious ailment? | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |
| 6.4 Are you or any of your dependants receiving any treatment at present? | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |
| 6.5 Are you or your dependants receiving any prescribed medication of any nature at present or within the last 12 months? | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |
| 6.6 Are you or your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment within next 12months? | YES | YES | YES | YES | YES | YES | YES | YES |
| | NO | NO | NO | NO | NO | NO | NO | NO |

If you have answered "YES" to any of the above questions please give full details below:

| Question No. | Column (A,B,C etc) | Details & dates |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## SECTION 7 DECLARATION - PLEASE READ CAREFULLY

**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: _____