BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

Administered by Associated Fund Administrators Botswana (Pty) Ltd.

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NOTICE OF WITHDRAWAL OF DEPENDENT

1. MEMBER DETAILS

(Please print all information in block letters, ONE LETTER PER BOX)

Initials Surname

First Names Telephone (Work)

Cell No Telephone (Res)

Email Address Fax Number

Postal Address

Nationality

Name of Employer

Membership Number

2. DETAILS OF THE DEPENDENTS TO BE WITHDRAWN

2.1 Surname

First Names

2.2 Surname

First Names

2.3 Surname

First Names

2.4 Surname

First Names

2.5 Surname

First Names

Reasons for Withdrawal

2.1: _____

2.2: _____

2.3: _____

2.4: _____

2.5: _____

Date: _____ Signature of Member: _____

Employer's date stamp: _____ Signature of Employer: _____