BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

Administered by Associated Fund Administrators Botswana (Pty) Ltd.

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REGISTRATION OF ADDITIONAL DEPENDENTS

1. MEMBER DETAILS

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

Title: Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ (Others Specify).....

Marital status: Single ☐ Married ☐ Widow ☐

Initials | Surname

First Names | Telephone (work)

Cell No | Telephone (Res)

Email Address | Fax Number

Postal Address

Nationality

Name of Employer

Membership Number

2. DEPENDENT DETAILS

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

Previous Medical Aid Schemes: _____
(Attach certificate of previous Medical Aid Schemes)

_____

_____

NOTE: * Please complete the medical history section in respect of the above dependent except, in the case of a new born (30days) and ensure that the application is signed by the member overleaf.

*Attach certified copy of marriage certificate for addition of spouse
*Attach copy of membership certificate from previous medical aid
*Attach certified copy of birth certificate for new born / affidafit for addition of children

Signature of Member: _____ Date: _____

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

DESCLAIMER

Upon admission of a dependent a member shall immediately inform the scheme of the occurrence of any event which results in anyone of his/her dependents no longer satisfy the conditions under which a dependent may be a dependent.

3. 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 "tick" in the adjacent block.	A 1st Dependant (Spouse)	B 2nd Dependant (Child)	C 3rd Dependant (Child)	D 4th Dependant (Child)	E 5th Dependant (Child)	F 6th Dependant (Child)	G 7th Dependant (Child)
3.1 Has the dependent ever been excluded from any benefit by any Insurance or Medical Aid Scheme?	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO
3.2 Has the dependent received any medical or orthodontical treatment during the last two years? (Please give dates)	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO
3.3 Is the dependent suffering from, or has suffered from any chronic or recurring illness or any serious ailment?	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO
3.4 Is the dependent expecting to undergo any procedure, operation, confinement or receive any major dental treatment within the next 12months?	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO
3.5 Is the dependent receiving any treatment at present?	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO
3.6 Is the dependent receiving any prescribed medication of any nature at present, or within the last 12 months ?	YES	YES	YES	YES	YES	YES	YES
	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

4. 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: _____