ADULT CHILD DEPENDANT APPLICATION FORM

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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

***Please complete in block letters, tick appropriate blocks unless otherwise indicated**

Requirements

- Complete the Adult Child Dependant form
- Have it signed and stamped by your employer
- Form to be completed by Principal member

Attachments

- Copy of certified birth certificate of adult child
- Recent payslip (not older than 2 months)
- Certificate of membership from previous medical aid (if any)
- Certified copy of grandchild/grandchildren birth certificate (if adding a grandchild)

SECTION 1 - 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 and should have been a member of BPOMAS for a continuous period of one (1) year

*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.

SECTION 2 - TYPE OF MEMBERSHIP

Standard Benefit **Up to P30,000 Cover** ☐	High Benefit **P300,000 cover** ☐	Premium Benefit **P500,000 cover** ☐
• No 10% Co-payment	• 10% Co-payment	• 10% Co-payment
• No hospitalization	• Hospitalization cover	• Hospitalization cover
• No chronic and dread disease cover	• Chronic & dread disease cover	• Chronic & dread disease cover
• P5, 000 Funeral benefit cover	• P10, 000 Funeral benefit cover	• P12, 5000 Funeral benefit cover
• 24Hr Emergency medical services	• 24Hr Emergency medical services	• 24Hr Emergency medical services
• Premium waiver (6months)	• Premium waiver (6months)	• Premium waiver (6months)

SECTION 3 - DETAILS OF THE MAIN MEMBER

Title ☐ Initials ☐ Surname

First name(s) Sex M ☐ F ☐ Date of Birth d d m m y y y y

Occupation

ID or passport number Country of Issue

Email

Cell Tel (H) Tel (W) Fax

SECTION 4 - DETAILS OF THE ADULT CHILD DEPENDANT

Title ☐ Initials ☐ Surname ID/Passport

First name(s) Sex M ☐ F ☐

Relationship Date of Birth

Cell Tel (H) Tel (W) Fax

Email

Postal Address	
Physical Address	

SECTION 5 - DETAILS OF THE GRANDCHILDREN

About your dependants (*only complete if adding a grandchild/grandchildren)

FAMILY MEMBERS TO BE COVERED

First Name & Surname(s)	Birth Dates D D M M Y Y Y Y	Gender	Identity Number/Birth Certificate or Passport Number

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

SECTION 6 - EMPLOYER WARRANTY

Name

Designation

Telephone

Authorised Signatory _____

Employer's Stamp

SECTION 7 - MEDICAL HISTORY OF THE ADULT CHILD DEPENDANT

Name of previous medical scheme/s	Medical aid number	Date joined	Date left

SECTION 8 - BANK DETAILS OF PRINCIPAL MEMBER (EMPLOYEE)

Please note: we can not accept credit card account details

Bank name _____ Branch name _____

Branch code _____ Account number _____

Type of account Current ☐ Savings ☐ Account holder _____

Basic Salary **P** _____

CONTRIBUTION TABLE

Membership category	Standard (P)	High (P)	Premium (P)
Under 21 years	137	251	488
21-30 years	296	461	684
31-35 years	305	584	979

SECTION 9 - MEDICAL HISTORY & GENERAL HEALTH INFORMATION OF THE ADULT CHILD DEPENDANT

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

OPTIONAL DISCLOSURE

With specific reference to and acknowledgement of the details contained in the Medical Details below, failure to disclose the chronic and dread disease or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion.

(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 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, 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 dependants 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.	Gynecological 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:

- 2 years for pre-existing chronic medical 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 next page. Please use a separate sheet of paper if the space provided is not enough.

Name of the person suffering from the illness		ddddddd		
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)				

SECTION 10- BRAND KNOWLEDGE

How did you hear about us? Newspaper ☐ Internet ☐ Radio ☐ Television ☐ Other _____

How would you like us to communicate with you? Sms ☐ Email ☐ Postal ☐

SECTION 11- NOMINATION OF FUNERAL BENEFIT PAY-OUT

In the event that the Parent Dependant member passes on, the person named below will be legible to claim for the funeral benefit payout.

Surname	
Name	
ID number	
Contacts	
Address	
Relation	

SECTION 12 - 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 dependants which occurs prior to my receiving written acceptance of this application.

In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission, dissemination of such information in line with the Scheme services.

Signature of Member:_____ Date:_____

SECTION 13 - BPOMAS COMMITMENT

The Scheme is committed to ensuring compliance with the Data Protection Laws of Botswana and that the information collected is used only for the purpose intended.

SECTION 14 - ADULT CHILD DEPENDANT APPLICATION FORM CHECKLIST

NB: Members will be subjected to sanctions Screening and Anti-Money Laundering/Combatting Financing of Terrorism & Proliferation (AML/CFT &P) due diligence measures.

	Yes	No	N/A	Comments
Certified copy of Adult child ID	☐	☐	☐	
Certified copy of Adult Child birth certificate	☐	☐	☐	
Copy of the member's payslip	☐	☐	☐	
Adult child's Certificate of previous medical aid cover (if any)	☐	☐	☐	