

CHANGE OF BENEFIT OPTION FORM

ADMINISTRATORS OFFICE GABORONE

Plot 54349, Ground Floor, West Wing,
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ADMINISTRATORS OFFICE FRANCISTOWN

Plot 44149 MVA Fund Building, 3rd Floor
Tel: +267 316 8902
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BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

Requirements

- Form must be signed and stamped by your employer

For Submissions

Form and attachments to be emailed to membership@bpomas.co.bw

- Member can only transfer from one benefit to the other on the first day of the financial year provided he has given one(1) month written notice

Attachments

- Recent payslip (not older than 3 months)

SECTION 1: SELECT YOUR HEALTH PLAN

Please select an option you like to Upgrade/Downgrade to

Standard Benefit Up to P30, 000 Cover	High Benefit P315, 000 Cover	Premium Benefit P500, 000 Cover
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> No 10% Co-Payment Limited Hospitalisation Cover Limited Chronic Medication Cover P5, 000 Funeral Benefit Cover 24Hr Emergency Medical Services Premium Waiver (6months) 24Hr Mental Health Assistance 	<ul style="list-style-type: none"> 10% Co-Payment Comprehensive Hospitalisation Cover Comprehensive Chronic Cover P10, 000 Funeral Benefit Cover 24Hr Emergency Medical Services Premium Waiver (6months) 24Hr Mental Health Assistance Wellness Benefit 	<ul style="list-style-type: none"> 10% Co-Payment Comprehensive Hospitalisation Cover Comprehensive Chronic Cover P12, 500 Funeral Benefit Cover 24Hr Emergency Medical Services Premium Waiver (6months) 24Hr Mental Health Assistance Wellness Benefit

SECTION 2: DETAILS OF PRINCIPAL MEMBER

Title Initials Surname

First Name(s) Sex M F Date of Birth

ID or Passport Number Nationality

Cell Alternate Cell Tel (H) Tel (W)

Email

Postal Address

Physical Address

SECTION 3: YOUR EMPLOYMENT DETAILS

Name of Employer

Occupation Basic Salary P Payroll Number

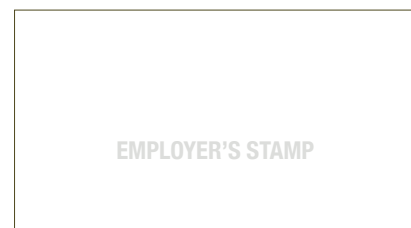
EMPLOYER WARRANTY

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.

Telephone

Postal Address

Authorised Signatory: _____



SECTION 4: 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 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 BPOMAS and its 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.

Signature of Member: _____ Date: _____

SECTION 5: CONSENT TO RECEIVE MARKETING MATERIAL

I consent to receive Marketing BPOMAS products, benefits, promotions and rewards. This can be performed through:

Email SMS Postal Address

Signature of Member: _____ Date: _____

SECTION 6: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

This Privacy Statement explains how BPOMAS collects, uses, stores, and protects Personal Information, including Sensitive Health Information, in the course of delivering medical aid services to our members. We are committed to protecting your privacy and ensuring compliance with the Data Protection Act (DPA) and other applicable international data protection laws.

1.1. What Personal Information We Collect

We may collect the following types of Personal and Sensitive Information:

- Full name, date of birth, identification numbers
- Contact details (e.g., address, phone, email)
- Membership and account details
- Medical history, treatment records, and diagnostic reports
- Claims and billing information

1.3. Legal Basis for Processing

We process your data under:

- Contractual obligation
- Consent to the processing of your Personal Information
- Performance of a legal obligation
- Protection of our and your legitimate or vital interests

1.5. Data Retention

We retain personal data only as long as necessary to:

- Fulfill our contractual and legal obligations
- Meet medical, billing, or reporting requirements
- Resolve disputes and enforce rights
- Retention periods are set based on legal, regulatory, and operational needs.

1.2. How We Use Your Data

We use your data to:

- Provide and manage medical aid services
- Process claims and benefits
- Coordinate care with healthcare providers
- Communicate with you about your membership or benefits
- Fulfill our legal, financial, and regulatory obligations
- Research and statistical purposes
- Transact with suppliers, business partners, and healthcare service providers
- General administration purposes pertaining to my membership

1.4. Data Sharing

We may share your data with:

- Medical professionals and healthcare providers
- Third-party administrators or service providers under contract
- Regulators, auditors, or insurers where legally required
- All third parties are subject to confidentiality and data protection agreements.

1.6. Data Security

We implement appropriate technical and organizational measures to protect your data, including:

- Encryption and secure data storage
- Role-based access controls
- Regular security audits and staff training

1.7. Your Rights

You have the right to:

- Access and obtain a copy of your information
- Correct inaccurate or incomplete information
- Object to processing under certain conditions
- Request erasure or restriction of your information
- Lodge a complaint with the Information and Data Protection Commission
- To exercise any of these rights, contact us at dataprotection@bpomas.co.bw.

1.8. Transfers of Personal Data outside of Botswana

Personal Information that we collect from you may be transferred to, and stored at, a destination outside of Botswana. It may also be processed by staff operating outside Botswana who are employees of our third-party providers. Where we transfer your Personal Information outside the jurisdiction, we will endeavour to ensure that there are adequate safeguards in place, in accordance with the DPA. By submitting your Personal Information, and in providing any Personal Information to us, you agree to this transfer, storing or processing.

SECTION 7: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

I acknowledge that;

I have read and understood the provisions of BPOMAS's Data Protection and Privacy Statement, thereby fully appreciating the manner in which BPOMAS may process my Personal Information and for which purpose(s) BPOMAS may process such Personal Information.

As a member I may supply BPOMAS with my next of kin's and dependents personal information – this will only be processed where required to protect legitimate interests or for BPOMAS legitimate business interests/contractual obligations. It is my responsibility to ensure that my next of kin and/or dependents do not object to the provision and or processing of their Personal Information.

In accordance with the provisions of the DPA, I have been provided with adequate notification of the processing of my Personal Information by BPOMAS, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so, and to request for access/destruction of my Personal Information that is held by BPOMAS.

In light of the above Acknowledgements and Privacy Statement, and in accordance with the requirements set forth in the Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information and that of my dependents for any purpose(s) legitimately connected or related to my application for membership.

Signature of Member: _____ Date: _____

SECTION 8: CHANGE OF BENEFIT OPTION FORM CHECKLIST

NB: Members will be subjected to sanctions Screenings and Anti-Money Laundering/Combatting Financing of Terrorism & Proliferation (AML/CFT & P) control measures as required by applicable legislations .

	Yes	No
Copy of Payslip	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Completed form and attachements to be emailed to membership@bpomas.co.bw