CHANGE OF BENEFIT OPTION FORM

ADMINISTRATORS OFFICE GABORONE

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ADMINISTRATORS OFFICE FRANCISTOWN

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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 Change of Benefit Option form
- Have it signed and stamped by your employer

- 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

- Copy of certified ID/Omang
- Recent payslip (not older than 2 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 **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, 00 Funeral benefit cover	• P12, 500 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 2 - ABOUT YOURSELF (PRINCIPAL MEMBER)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname

First name(s) Sex M ☐ F ☐ Date of birth

Occupation Payroll number

Membership Number ID or Passport Number

Country of Issue

Cell Tel (H) Tel (W) Fax

Email

Postal Address	
Physical Address	

SECTION 3 - YOUR EMPLOYMENT DETAILS

Name of Employer

Occupation Date of employment d d m m y y y y

Basic Salary P

EMPLOYER WARRANTY

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.
Botswana Public Officers' Medical Aid Scheme may bill us for the amount due for this member in the same way as it does for our other employees with Botswana Public Officers' Medical Aid Scheme (BPOMAS).

Name

Designation

Email

Telephone

Postal Address

EMPLOYER'S STAMP

Authorised signatory:___ ___.___ _ _____ _ _____

SECTION 4 - YOUR BANKING DETAILS

Please note: we can not accept credit card account details

Branch name

Bank name

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

Account holder

SECTION 5 - NOMINATION FOR FUNERAL BENEFIT PAY-OUT

In the event that the principal 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 6- 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 7 - 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 8 - CHANGE OF BENEFIT OPTION 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
Copy of payslip	☐	☐	☐	