NEW MEMBER APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE
Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

WHY JOIN BPOMAS

As the market leading medical aid scheme in Botswana, we offer you the most affordable medical aid options to suit your individual and family needs, through industry-leading coverage and affordable monthly premiums.

Requirements

- Complete the New Member application form
- Have it signed and stamped by your employer

Attachments

- Copy of certified valid identification documents (Omang for citizens & passport for foreign nationals)
- Recent payslip (not older than 2 months)
- Spouse's certified ID copy and marriage certificate (if adding spouse)
- Children's certified birth certificates (if adding children)
- Certificate of membership from previous medical aid (if any)

SECTION 1 - SELECT YOUR HEALTH PLAN

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, 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 - DETAILS OF PRINCIPAL MEMBER

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname

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

Occupation Payroll number

ID or passport number Country of Issue

Email

Cell Tel (H) Tel (W) Fax

Postal Address	
Physical Address	

SECTION 3 - ABOUT YOUR SPOUSE (only complete if adding spouse)

Title ☐ Initials ☐ Surname

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

Employer

ID or passport number Country of issue

Cell Tel (H) Tel (W)

Email

SECTION 4 - ABOUT YOUR CHILD DEPENDANTS

About your dependants (*only complete if adding child dependants)

FAMILY MEMBERS TO BE COVERED

First Name & Surname(s) attach certified copy of child's birth certificate	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 5 - YOUR MEDICAL AID HISTORY

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

SECTION 6 - YOUR EMPLOYMENT INFORMATION

Name of Employer

Occupation Basic Salary **P** Date of employment d d m m y y y y

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 7 - BANK DETAILS OF PRINCIPAL MEMBER

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

SECTION 8 - MEDICAL HISTORY & GENERAL HEALTH INFORMATION

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				
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 9- 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 10- NOMINATION OF 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 11- 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 12 - 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 13 - NEW MEMBER 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 Omang (Passport for foreign nationals)				
Copy of payslip or confirmation letter stating basic salary				
Certified copy of Omang and marriage certificate (if adding spouse)				
Certified copies of birth certificates (if adding children)				
Certificate of previous medical aid cover (if any)				