PARENT DEPENDANT APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE

Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
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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**

Botswana has implemented a law known as the Financial Intelligence Act and its Regulations, to combat money laundering (and other financial crimes), which is the abuse of financial systems to hide and/or disguise the proceeds of crime. In terms of this Act and its Regulations, BPOMAS is required before establishing a business relationship or carrying out a transaction, to obtain and verify, at a minimum, a prospective customer's identity, address and source of funds.Please play your part as a member to assist us in complying with these customer due diligence obligations by completing this form and submitting the attachments listed below.

Requirements

- The form must signed and stamped by your employer
- Duly completed Medical Report
- Duly completed Sworn Affidavit report

Attachments

- Copy of certified parent ID
- Recent payslip (not older than 3 months)
- Certificate of membership from previous medical aid (if any)

SECTION 1: RULE EXTRACTS OF INDIVIDUAL MEMBERSHIP

1. Parent Dependant refers to the Principal member's biological/adoptive mother or father and/or the biological/adoptive mother or father of the spouse who is not a pensioner
2. The maximum entry age is 65 years for Parent Dependant
3. A medical report not more than a month old is required for Parent Dependant
4. A 3 month waiting period shall apply to the Parent Dependant

*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 **P315,000 Cover** ☐
• No 10% Co-Payment	• 10% Co-Payment
• Limited Hospitalisation Cover	• Comprehensive Hospitalisation Cover
• No Chronic and Dread Disease Cover	• Chronic and Dread Disease Cover
• P5, 000 Funeral Benefit Cover	• P10, 000 Funeral Benefit Cover
• 24Hr Emergency Medical Services	• 24Hr Emergency Medical Services
• Premium Waiver (6months)	• Premium Waiver (6months)
• 24Hr Mental Health Assistance	• 24Hr Mental Health Assistance
	• Wellness Benefit

SECTION 3: DETAILS OF THE PRINCIPAL MEMBER

Membership Number _____ ID or Passport Number _____

Email _____ Cellphone Number _____

Postal Address _____

SECTION 4: DETAILS OF THE PARENT DEPENDANT

Title _____ Initials _____ Surname _____ ID/Passport _____

First Name(s) _____ Sex M ☐ F ☐

Relationship _____ Date of Birth _____

Cell _____ Tel (H) _____ Tel (W) _____

Email _____

Postal Address	
Physical Address	

SECTION 5: PRIMARY CONTACT: PRINCIPAL ☐ APPLICANT ☐

Declaration: I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform The Scheme of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Signature of Member: _____ Date: _____

IMPORTANT
Failure to complete all information and attached documents 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

Employer's Stamp

Authorised Signatory: _____

SECTION 7: MEDICAL AID HISTORY OF THE PARENT DEPENDANT

Name of Previous Medical Scheme/s	Date Joined	Date Left

SECTION 8: BANK DETAILS OF APPLICANT

Please note: we can not accept credit card account details

Bank Name Branch Name

Branch Code Account Number

Account Type Current ☐ Savings ☐ Basic Salary **P**

Account Holder

CONTRIBUTION TABLE

Membership Category	Standard (P)	High (P)	Premium (P)
Parent Dependant	444	1768	N/A

LATE JOINER PENALTY

Any applicant who is fifty (50) years of age or older who was not a member of one or more medical schemes at the time of joining the Scheme will incure a penalty by way of additional contributions as per Scheme rules as follows;

Years member was not a member of medical aid since the age of 50	Late joiner penalty
1-4 years	1.25
5-14 years	**1.5**
15-24 years	1.75
25 years +	**2**

SECTION 9: MEDICAL HISTORY & GENERAL HEALTH INFORMATION OF THE PARENT 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 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 abnormal 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 currently undergoing or anticipating any specialised dental, maxillofacial treatment?	Yes	No
13.	Have you had any accidents (including motor vehicle accidents)? If yes; confirm injuries sustained in accident and if there is any temporary or permanent injuries, and if you require any current of future treatment.	Yes	No
14.	Are taking ongoing medicine for any condition no listed in any other of the questions?	Yes	No
15.	Have you had any surgical procedure?	Yes	No
16.	Are you 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.	Gynaecological 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 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.
- 3 months waiting period.

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 Person suffering from the Illness	Question Number	Name of the Condition	Date Diagnosed	Name of Medication	Date of Last Treatment / Medication	Date of Last Symptoms	Attending Doctor

SECTION 10: 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 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.

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.

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: CONSENT TO RECEIVE SCHEME UPDATES & MARKETING MATERIAL

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

Email ☐ SMS ☐ Phone ☐ Postal Adress ☐

Signature of Member:_____ Date:_____

SECTION 14: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

Data protection is a matter of trust and your trust is important to us. We respect your right to confidentiality and privacy and, we are committed to complying with the Data Protection Act. The protection and the lawful collection, processing and use of your personal data is therefore an important concern for us in the provision of our services to our members.

SECTION 15: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

15.1 Acknowledgement

I hereby expressly acknowledge that the processing off my Personal Information and/or Special Personal Informantion by BPOMAS ("collectively referred to as "Personal Information"), as defined in terms of the Data Protection Act of 2018 (DPA). I acknowledge that;

15.1.1 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.

15.1.2. Through submitting this application, I am providing BPOMAS with my Personal Information and that engaging with BPOMAS through any physical and/or electronic means, BPOMAS will in effect be processing the Personal Information provided by me from time to time.

15.1.3 BPOMAS may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.

15.1.4 I fully appreciate that BPOMAS will only process my Personal Information in a manner consistent with the provisions of its Data Protection Act, as well as for the purpose(s) set forth therein.

15.1.5 In accordance with the provisions of Section 28 of 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.

15.1.6 I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

15.1.7 I have read and understood the undertakings made by BPOMAS in its Data Protection and Statement to the effect that it will ensure that any and all of personal Information shall be processed with a reasonable standard of care as may be expected from BPOMAS.

15.2 Consent

In light of the above acknowledgements, and in accordance with the requirements set forth in Section 20 of Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:

15.2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.

15.2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the BPOMAS.

15.2.3 To facilitate the delivery of products and/or services to me as a member of BPOMAS to administer my claims and premiums.

15.2.4 To activate my medical aid and/or prescribed benefits to allocate a unique identifier (membership number) to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.

15.2.5 To transact with suppliers and business partners, including healthcare service providers, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.

15.2.6 To provide me with health and wellness information throughout the subsistence of my membership.

14.2.7 To transact with third parties and transfer my Personal Information (locally or across border) to such third parties for the purpose of enabling BPOMAS to fulfil its legitimate pursuit of contractual obligations towards me and within the requirements of the Data Protection Act.

15.2.8 To analyse and profile my Personal Information collected for research and statistical purposes.

15.2.9 For general administration purposes pertaining to my membership.

Signature of Member:_____ Date:_____

SECTION 15: PARENT DEPENDANT APPLICATION 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
Certified Copy of the Parent ID	☐	☐
Sworn Affidavit or Certified Copy of Members Birth Certificate	☐	☐
Copy of the Principal Member's Payslip	☐	☐
One Month Valid Medical Report	☐	☐

MEDICAL REPORT FORM

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

SECTION 1: APPLICANT DETAILS

Name	
Gender	
Date of Birth	
ID Number	
Mobile Number	
E-mail address	

SECTION 2: GENERAL EXAMINATION

Height _____ Weight _____

BP _____ Resp Rate _____

General Appearance: _____

_____

SECTION 3: PAST MEDICAL HISTORY

Problem 1: _____

_____

_____

Problem 2: _____

_____

_____

Problem 3: _____

_____

_____

Medication and doses _____

_____

Medication and doses _____

_____

Medication and doses _____

_____

Medication and doses _____

_____

_____

	Examination findings	Normal	Abnormal	If abnormal comment
Eyes	Conjuctivae & Lids	☐	☐	_____
	Pupils & Irise			_____

	Examination findings	Normal	Abnormal	If abnormal comment
Ear, Nose, Mouth & Throat	External Inspection	☐	☐	
	Otoscopic exam			
	External Auditory Canal	☐	☐	
	Tympanic Membranes	☐	☐	
	Hearing Assesmen	☐	☐	
	Nasal Mucosa, Septum & Turbinales	☐	☐	
	Lips, Teeth & Gums	☐	☐	
	Oropharynx	☐	☐	
	Oral Mucosa, Salivary Glands			
	Hard/Soft Palates, Tongue			
	Tonsil & Posterior Pharynx			
Neck	Neck. Tracheal Position	☐	☐	
	Thyroid	☐	☐	
Respiratory	Respiratory Effort	☐	☐	
	Percussion of Chest	☐	☐	
	Palpation of Chest	☐	☐	
	Auscultation of Lungs	☐	☐	
Abdo	Inspection	☐	☐	
	Palpation	☐	☐	
	Auscultation	☐	☐	
Cardiovascular	Palpation of Heart	☐	☐	
	Ausulation of Heart	☐	☐	
CNS	Mental Status	☐	☐	
	Muscle Strength	☐	☐	
	Tone	☐	☐	
	Sensory Function	☐	☐	

SECTION 4: SUMMARY OF FINDINGS

Name of Medical Practitioner: _____

Signature: _____

Practice Name/ Clinic/Hospital: _____

Contact Details

Email: _____

Tel: _____

Cell: _____

Doctor/Practice stamp

SWORN AFFIDAVIT

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I _____ of ID no _____ and address (residential and postal) _____ do hereby solemly declare that _____ of ID no _____ and address (residential and postal) _____ is my biological mother/father/mother in law/father in law. I accept full responsibility for notifying the Scheme in writing if there are any changes pertaining to this relationship.

I declare that I am responsible for his/her essential needs such as food, clothing and health. I agree to provide any supporting documentation as may be required from time to time in support of this affidavit.

I recognize that this affidavit is a legally binding document. I understand that it would be unlawful to knowingly make or cause to be made any false material statement or material representation, omit to disclose a material fact or to otherwise provide false information with the intent to use it or allow it to be used to obtain, receive or continue to receive, increase or deny or reduce any benefit offered by the Scheme.

I understand the contents of this declaration and have no objection to taking the prescribed oath.

I declare that all the information given above is true, correct, and binding on my conscience.

_____
Deponent

Sworn before me on _____ day of _____ at _____(place) _____ (time).

_____
Commissioner of Oaths (name)

_____
Commissioner of Oaths (signature)

Stamp