

# PARENT DEPENDANT APPLICATION FORM

ADMINISTRATORS OFFICE  
GABORONE

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The Field Precinct, CBD  
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ADMINISTRATORS OFFICE  
FRANCISTOWN

Plot 44149 MVA Fund Building, 3rd Floor  
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**\*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

- Duly completed Medical Report
- Duly completed Sworn Affidavit

## For Submissions

- Form and attachments to be emailed to [join@bpomas.co.bw](mailto:join@bpomas.co.bw)

## 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: SELECT YOUR HEALTH PLAN

Standard Benefit  
**Up to P30, 000 Cover**

- No 10% Co-Payment
- Limited Hospitalisation Cover
- Limited Chronic Cover
- P5, 000 Funeral Benefit Cover
- 24Hr Emergency Medical Services
- Premium Waiver (6months)
- 24Hr Mental Health Assistance

High Benefit  
**P315,000 Cover**

- 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

## SECTION 3: DETAILS OF THE PRINCIPAL MEMBER

Membership Number  ID or Passport Number

Cell  Email

Postal Address

## SECTION 4: DETAILS OF THE PARENT DEPENDANT

Title  Initials  Surname

First Name(s)  Sex M  F  Date of Birth

ID/Passport  Nationality

Cell  Alternate Cell  Email

Postal Address

Physical Address

## SECTION 5: MEDICAL AID HISTORY OF THE PARENT DEPENDANT

Name of Previous Medical Scheme/s	Date Joined	Date Left

## SECTION 6: BANK DETAILS OF THE PRINCIPAL MEMBER

**Note: We do not accept credit card account details. The provided banking details should be those of the Principal Member.**

Bank Name  Branch Name

Account Type  Account Type Current  Savings

Account Holder

### 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 incur 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

## CONTRIBUTION TABLE

Membership Category	Standard (P)	High (P)	Premium (P)
Parent Dependand	510	2,015	N/A

## SECTION 7: MEDICAL HISTORY & GENERAL HEALTH INFORMATION OF THE PARENT DEPENDANT

Kindly complete the medical questions below for the Parent dependants being covered. Failure to disclose pre-existing conditions (including but not limited to chronic and dread disease), could limit and/or exclude benefits or result in termination of your membership or such other measures as the Scheme may determine in its sole discretion.

**Medical questions to be completed for Parent Dependand only. Main member medical information not required.**

(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 cardiovascular system, e.g heart murmur, high blood pressure, high cholesterol, shortness of breath, palpitations, chest pains, angina, heart attack and/or other cardiac or blood disorders.	Yes	No
3.	Respiratory or lung disorders, e.g tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis.	Yes	No
4.	Disorders in the digestive system, stomach, gall bladder, pancreas 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 you 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 or future treatment.	Yes	No
14.	Are you taking ongoing medicine for any condition not 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 waiting period.

**SECTION 7.1 MEDICAL HISTORY DETAILS**

<b>If you have ticked yes on section 7 please provide more details below.</b>							
Name of Person suffering from the Condition	Question Number	Name of the Condition	Date Diagnosed	Name of Medication	Date of Last Treatment / Medication	Date of Last Symptoms	Attending Doctor

## SECTION 8: NOMINATION OF FUNERAL BENEFIT PAYOUT

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

Surname	<input type="text"/>
Name	<input type="text"/>
ID Number	<input type="text"/>
Contacts	<input type="text"/>
Address	<input type="text"/>
Relation	<input type="text"/>

## SECTION 9: 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 10: 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 11: 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

### 1.2. 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
- Fulfil 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

### 1.3. 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:

- Fulfil 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.

### 1.7. 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](mailto: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.

### 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

## SECTION 12: 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: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 13: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

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- Research and statistical purposes
- Transact with suppliers, business partners, and healthcare service providers
- General administration purposes pertaining to my membership

### 1.3. Legal Basis for Processing

## SECTION 14: 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	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
Sworn Affidavit or Certified Copy of Members Birth Certificate	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
Copy of the Principal Member's Payslip	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
One Month Valid Medical Report	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE:** Completed form and attachments to be emailed to [join@bpomas.co.bw](mailto:join@bpomas.co.bw)

# MEDICAL REPORT FORM

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BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

**\*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: \_\_\_\_\_  
\_\_\_\_\_

Medication and doses \_\_\_\_\_  
\_\_\_\_\_

Problem 2: \_\_\_\_\_  
\_\_\_\_\_

Medication and doses \_\_\_\_\_  
\_\_\_\_\_

Problem 3: \_\_\_\_\_  
\_\_\_\_\_

Medication and doses \_\_\_\_\_  
\_\_\_\_\_

	Examination findings	Normal		Abnormal		If abnormal comment
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	Conjunctivae & Lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Pupils & Iris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

#### SECTION 4: SUMMARY OF FINDINGS

Name of Medical Practitioner: \_\_\_\_\_

Signature: \_\_\_\_\_

Practice Name/ Clinic/Hospital: \_\_\_\_\_

**Contact Details**

Email: \_\_\_\_\_

Tel: \_\_\_\_\_

Cell: \_\_\_\_\_

Doctor/Practice  
stamp

# SWORN AFFIDAVIT

### ADMINISTRATORS OFFICE GABORONE

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BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

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

I  of ID no   
and address (residential and postal)  do hereby solemnly  
declare that  of ID no   
and address (residential and postal)   
is my biological/adoptive mother/father or mother in law/father in law. I accept full responsibility for notifying the Schemet ~~the relevant~~ <sup>relevant</sup> authority  
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)

