SWORN AFFIDAVIT

ADMINISTRATORS OFFICE GABORONE

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bpomas
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 solemly declare that _____ of ID no _____ and address (residential and postal) _____ is/are my biological grandchild/grandchildren. 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