

International Student Scheme

The date you want your cover to start:

D	D	M	M	Y	Y	Y	Y
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Shaded Areas for office use only

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Membership Number

Application Form

Section A - Institution Details

Institution Name																				
Primary <input type="radio"/> Secondary <input type="radio"/> Tertiary <input type="radio"/> (Please tick where applicable)																				
Student Number																				

Section B - Principal Details

Surname																					
First Names (In full)																			Male / Female (Please tick where applicable)	M	F
Identity No.																					
Passport No.																					
Postal Address.																					
P/BAG																					
Home Phone.																					
Work Phone																					
Email Address 1																					
Email Address 2																					

Note: Copy of ID/Passport to the attached form - legally required
Current proof of schooling.

<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	BOMaid Bank Account: First National Bank of Botswana - Main Mall BranchCode: 282267 Account Number #: 571 3111 3369 reference: use your membership number
<input type="checkbox"/> Bi-Annually	<input type="checkbox"/> Annually	

Section C - Your Payment - Member Information - Banking Details

Self <input type="radio"/>	Parent/Guardian <input type="radio"/>	(Please tick where applicable)															
Surname <small>(if Parent/Guardian)</small>																	
Name																	
Bank Name																	
Branch Name																	
Branch Code					Account Type												
Account Number																	

I / We hereby instruct and authorise Botswana Medical Aid Society to draw against my / account with the above named bank / our monthly subscriptions on the day of each month commencing..... And continuing until further notice in writing from me/us. All such withdrawal from my / our account shall be treated as though they have been signed by me / us personally. I / We authorise Botswana Medical Aid Society to automatically update the monthly subscriptions due to member changes and annual subscriptions adjustment without the need to sign new debit order authorisation. This instruction may be cancelled by me / us by giving a 30 days notice in writing, sent by registered mail or delivered to the society's offices, but I / We understand that I / We shall not be entitled to any refund of amounts which the Society may have already withdrawn while this authorisation was in force, if such amounts were legally owing to the Society. Receipt of this instruction by the Society shall be regarded as a receipt thereof by my / our bank.

Signature	
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Date	
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Section D - Next of kin

Relationship																	
Surname																	
Name																	

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Application Form Continued.....

Identity No.																								
Passport No.																								
Email Address 1																								
Email Address 2																								

Section E - Confidential Medical History

<i>Please tick either Yes/No to each of these questions. Do you have, or have you ever had any of the following</i>	Principal Member name	
	Yes <input type="radio"/>	No <input type="radio"/>
1. Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attacks or other cardiac/vascular disorder?	<input type="radio"/>	<input type="radio"/>
2. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder?	<input type="radio"/>	<input type="radio"/>
3. Nephritis, prostate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder?	<input type="radio"/>	<input type="radio"/>
4. Diabetes, sugar in blood/urine, glandular disorder, goitre or any other endocrine disorder?	<input type="radio"/>	<input type="radio"/>
5. Conditions of joints or spine including rheumatism, arthritis, neck or back disorder?	<input type="radio"/>	<input type="radio"/>
6. Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukemia, skin cancer, lesion or any other related problems?	<input type="radio"/>	<input type="radio"/>
7. Ulcers (gastric or duodenal hiatus cancer, lesion or any other related problems dysentery, gastro-intestinal or abdominal obstructions or any other related disorders?	<input type="radio"/>	<input type="radio"/>
8. Nervous or mental complaint e.g. epilepsy convulsions, dizziness, blackouts, paralysis meningitis, anxiety states, depression, alcoholism meningitis, anxiety states, depression, alcoholism	<input type="radio"/>	<input type="radio"/>
9. Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision tonsillitis, gromets, injuries, or any other ENT disorders?	<input type="radio"/>	<input type="radio"/>
10. Diseases of the reproductive system e.g. infertility, ovarian cysts, uterine fibroids, abnormality of pregnancy or confinement or any other related reproductive system disorder?	<input type="radio"/>	<input type="radio"/>
11. Expecting or planning to have a baby? State the dates	<input type="radio"/>	<input type="radio"/>
12. Sexually transmitted diseases e.g. syphilis gonorrhoea, HIV /AIDS related illness or any other sexually transmitted diseases?	<input type="radio"/>	<input type="radio"/>
13. Any physical disabilities or injuries?	<input type="radio"/>	<input type="radio"/>
14. Any congenital disease/disability?	<input type="radio"/>	<input type="radio"/>
15. Any special dental treatments e.g. crown bridge prosthodontic and orthodontic appliances or any other dental problems?	<input type="radio"/>	<input type="radio"/>

Section F - Additional Information

This section applies if you have indicated "YES" to any questions in section E, if you are unsure whether any details are relevant, you must include them. Please indicate the relevant question number from section E in brackets ()

<i>Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected e.g. right leg, left eye</i>	()
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	()

(PLEASE TURN OVER)

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Application Form Continued.....

<i>When did the symptoms start and when was treatment completed</i>	()
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<i>What treatment did you receive and when (please include dates, names and details of medications)?</i>	()
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<i>What was the outcome of the treatment (e.g ongoing, complete, recovery, recurrent or likely to recur)?</i>	()
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