Bomaid

The medical aid you can trust

International Student Healthplan

The date you want your cover to start:

D	D	M	M	Y	Y	Y	Y

Shaded Areas for office use only

Membership Number

Application Form

Section A - Institution Details

Institution Name

Primary ○ Secondary ○ Tertiary ○ (Please tick where applicable)

Student Number

Section B - PrincipalDetails

Surname

First Names (In full)

Male / Female (Please tick where applicable) M F

Identity No.

Date of Birth

Passport No.

Nationality

Postal Address.

P/BAg

Home Phone.

Cell Phone 1

Work Phone

Cell Phone 2

Email Address 1

Email Address 2

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

☐ Monthly ☐ Quarterly

☐ Bi-Annually ☐ Annually

Bomaid Bank Account:
First National Bank of Botswana - Main Mall
BranchCode: 282267
Account Number #: 571 3111 3369
reference: use your membership number

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International Student Scheme

Section C - Your Payment - Member Information - Banking Details

Self ○ Parent/Guardian ○ (Please tick where applicable)

Surname (if Parent/Guardian)

Name

Bank Name

Branch Name

Branch Code

Account Type

Account Number

I / Wehereby instruct and authorise Botswana Medical Aid Society to draw against my / account with the above named bank / our monthly subscriptions on the .... dayof eachmonth commencing.................................. And continuing until further notice in writing from me/us. All such withdrawal from my / our accunt 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 adjusment 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'soffices, but I / We understand that I / We shall not be entitled to any refund of amouns which the Society may have already withdrawn while this authorisation was in force, if such amounts were legally owing to the Society.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

Date

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

Please tick either Yes/No to each of these questions. Do you have , or hav eyo eveer had any of the following	Principal Member name	
	Yes	No
1. Shortness of breath, palpitations, raised chelestrol, stroke, raised blood pressure, heart murmur, angina, heart attacks or other cardiac/vascular disorder?	○	○
2. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other relatedrespiratory disorder?	○	○
3. Nephritis, prostrate problems, kidney stone,congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder?	○	○
4. Diabetes, sugar in blood/urine, glandular,disorder, goitre or any other endocrine disorder?	○	○
5. Conditions of joints or spine including rheumatism, arthri, neck or back disorder?	○	○
6. Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukema, skin cancer, lesion or any other related problmes?	○	○
7. Ulcers (gastric or duodenal hiatus, hiatus cancer, lesion or any other related problmes dysentery, gastro-intestinal or abdominal obstructions or any other related disorders?	○	○
8. Nervous or mental complaint e.g. epilespsy convulsions, dizziness, blackouts, paralysis meningitis,anxiety states, dpression, alcoholism meningitis,anxiety states, dpression, alcoholism	○	○
9. Ear, eye, nose, throat problem, icluding ear discharge, hearing loss, defective vision tonsillitis, groments, injuries, or any other ENT disorders?	○	○
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?	○	○
11. Expecting or planning to have a baby? State the dates	○	○
12. Sexually transmitted diseases e.g sysphilis.gonorrhoea, HIV /AIDS relatedilliness or any other sexually transmitted diseases?	○	○
13. Any physical disabilities or injuries?	○	○
14. Any congenital disease/disability?	○	○
15. Any special dental treatments e. crown bridge prothodontic and orthodontic appliances or any other dental problems?	○	○

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 the,.
Please indiate the revelant question number from section E in brackets ()

Please specify as accuately 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	( )
	( )
	( )
	( )
	( )
	( )

(PLEASE TURN OVER)

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Application Form Continued......

When did the symptoms start and when was treatment cimpleted	( )
	( )
	( )
What treatmet did you recieve and when (please include dates, names and details of 'medications)?	( )
	( )
	( )
	( )
What was the outcome of the treatment (e.g ongoing, complete, recovery, recurrent or likey to recur)?	( )
	( )
	( )
	( )