Bomaid
Health & Happiness at heart

Change of Employment

1. PRINCIPAL MEMBER DETAILS -To be completed by the principal member

Name

Surname

Membership Number

Male / Female M F

ID number / Passport No

Home phone

Work phone

Cell Phone 1

Cell Phone 2

Postal Address

Email Address

2. SCHEME - (Please tick one box only)

A Healthplan ◯ B Healthplan ◯ C Healthplan ◯ Student Healthplan ◯ Scheme A Healthplan ◯

No co-payment (A) (B) (C)

3. HEALTH OPTION - (Please tick one box only - current level of dependants covered)

M ◯ M + 1 ◯ M + 2 ◯ M + 3 ◯ M + 4 ◯

4. DEPENDENTS (to be included in the membership)

	Dependants Names	Relation to Member	Dependant ID Number	Date of Birth
1				
2				
3				
4				
5				

If there is a new dependents, a complete Medical History Form (B3) must accompany this form.

Is any of your above listed dependant(s) covered under ANY other Bomaid healthplan/membership? Yes ◯ No ◯

If YES, specify membership number(s)

5. EMPLOYMENT DETAILS

Name of Employer

Position

Date of Employment D D M M Y Y Y Y

6. SALARY DETAILS (Tick Applicable Salary)

Actual Salary P

Name of Employer

Signature (Principal member)

Signature (Employer)

Date