Bomaid
The medical aid you can trust

Membership Application Form

Membership Number									

1 Principal Member: Your personal details

The date you want your cover to start	D D M M Y Y Y Y	Date of birth	D D M M Y Y Y Y	Age		Age Next Birthday	

Title		First name(s)	
Surname		Identity/ Passport No.	
Male / Female (Please tick where appropriate)	M ☐ F ☐	Nationality	
Marital Status	S ☐ M ☐ D ☐ W ☐	Educational Background	Certificate ◯ Diploma ◯ Degree ◯ Masters ◯ PHD ◯ Others ◯
Home phone		Cell Phone 1	
Work Phone		Cell Phone 2	
Email Address 1			
Email Address 2			
Postal Address			
Residential Address			

Dependants (to be included in the membership)

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

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

If YES, specify membership number(s) _____

Your Scheme Cover - Level of cover (Please tick one box only)

Healthplan A ◯ Healthplan B ◯ Healthplan C ◯ International Student Healthplan ◯ Healthplan A Standard ◯

Actual Salary	

4 Employment details (New companies should enclose a copy of their certificate of incorporation)

Name of Current employer																							
Position held													Date of employment	D	D	M	M	Y	Y	Y	Y
Name of previous or current medical insurer													Cover period from	D	D	M	M	Y	Y	Y	Y
													Cover period to	D	D	M	M	Y	Y	Y	Y

Economic Sector

Agriculture ◯ Manufacturing ◯ Electricity & Water ◯ Finance ◯ Real Estate ◯

Mininig & Quarrying ◯ Construction ◯ Hotels & Restaurant ◯ Transport & Communication ◯ Education ◯

Health ◯ Wholesale & Retail Trade ◯ Other _____

Company Stamp/Representative Stamp

5 Applicant's banking details (Tick where applicable) Direct Debit ☐ Claims Payment ☐

Bank Name																							
Branch Name																							
Branch Code																							
Account Type																							
Account Number																							
Payer Fullname																							
Contact Details											Email Address												
Bank Name											Account Number												
Branch Name											Accountant Type												

I / We hereby instruct and authorise Botswana Medical Aid Society to draw against my / our account with the above named bank my / our monthly subscriptions on the .....day of each month commencing _____. All such withdrawals 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 adjustments 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.

Membership Number

6 Confidential medical history

Please tick either Yes or No to each of these questions, for each person to be covered

Do you have, or have you ever had any of the following?

	Principal member Full Name		1st additional dependant Full Name		2nd additional dependant Full Name		3rd additional dependant Full Name		4th additional dependant Full Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attack or any other cardiac/vascular disorder?	○	○	○	○	○	○	○	○	○	○
2. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other urinary/kidney disorder?	○	○	○	○	○	○	○	○	○	○
3. Nephritis, prostate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney dsorder?	○	○	○	○	○	○	○	○	○	○
4. Diabetes, sugar in blood/urine, granular disorder, goitre or any other endocrine disorder?	○	○	○	○	○	○	○	○	○	○
5. Conditions of joint or spine including rheumatism, arthritis neck or back disorder?	○	○	○	○	○	○	○	○	○	○
6. Any lumps, growths (benign or malignant), cancer, Hodgkin's disease, leukaemia, skin cancer, lesion or any other related problems?	○	○	○	○	○	○	○	○	○	○
7. Ulcers (gastric or duodenal hiatushiatus hernia) gall bladder problems, hepatitis, dysentery, gastro-intestinal or abdominal obstructions or any other related disorders?	○	○	○	○	○	○	○	○	○	○
8. Nervous or mental complaint e.g. epilepsy, convulsions, dizziness, blackouts, paralysis, meningitis, anxiety states, depression, alcoholism, narcotism or any other related disorders?	○	○	○	○	○	○	○	○	○	○
9. Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision, tonsillitis, grommets, injuries, or any other related 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. syphilis, gonorrhoea, HIV/AIDS related illnesses or any other sexually transmitted diseases?	○	○	○	○	○	○	○	○	○	○
13. Any physical disabilities or injuries?	○	○	○	○	○	○	○	○	○	○
14. Any congenital diseases/disability?	○	○	○	○	○	○	○	○	○	○
15. Any special dental treatments e.g. crown, bridge, prothodontic and orthodontic appliances or any other dental problems?	○	○	○	○	○	○	○	○	○	○

7 Additional information

This section applies if you have indicated "YES" to any questions in section 6.

	The relevant question number from section 6	When last did you see your doctor and for what reason?	Do you have any chronic condotiond that may need mediacal attention within the next twelve months?	List details of medications used in the last twelve months and related conditions?
Principal member				
Dependant 1				
Dependant 2				
Dependant 3				
Dependant 4				

8 Your doctor

Doctor's name	
Postal Address	Work phone
	Email address

IMPORTANT INFORMATION

Please be aware that this form must be received by Botswana Medica Aid Society no more than six weeks after the declaration date.

It is advisable that you fill in your form with complete up-to-date medical history before you sign and date this form.

Please register new-borns within 48 hours with or without birth certificate.

Adding a spouse: Please attach a copy of your marriage certificate.

Adding a child dependant: Please attach a copy of the birth certificate or affidavit.

Confidentiality: All member information given to Bomaid is guaranteed to be confidential and shall only be used for purposes related to customer service.

Dual membership: No dual membership is allowed.

How did you get to know about Bomaid?

☐ Social Media ☐ Employer ☐ TV

☐ Website ☐ Print Media

Other _____

_____

_____

Disclaimer

I/ We Declare that the information on this form is to the best of my knowledge true and correct. I/We further acknowledge that Botswana Medical Aid Sociey accepts no responsibility or liability for the accuracy of the information provided by myself. If I am illiterate, I confirm that the contents of this application form and the implications thereof have been read explained to me.

Signature	Date