

## CHANGE OF EMPLOYMENT APPLICATION FORM

Membership Number

### 1. Principal Member Details - To be completed by the principal member

Title  First name (s)

Surname  ID/Passport No.

Male / Female  M  F  Nationality

Home Phone  Cellphone 1

Work Phone  Cellphone 2

Postal Address

Physical Address

### 2. Your Health Plan (Please tick one box only)

ISS (Student)  Access  Comprehensive  Executive  Prestige

Take note that each Health Plan has four levels of cover Core, Plus, Extra and Max. Core is entry level whilst Max is the top tier cover.

Please select the desired level of cover under the chosen Health Plan:

Core  Plus  Extra  Max

For more information, please refer to Health Plan booklet or enquire from Bomaid Sales personnel.

### 3. Dependents (to be included in the membership)

Dependents names	Relation to member	Dependants ID number	Date of Birth
1.			
2.			
3.			
4.			
5.			

If there is a new dependents, a complete additional dependant form 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) and provide certificates of membership

### 4. Employment details

Name of employer  Position

Date of Employment

Employer Stamp

### 5. Salary Details

Actual salary P  Name of employer

Signature ( Employer )  Signature (Principal member)  Date

## 6. Client Information Consent

In terms of the Data Protection Act Bomaid is obligated to obtain the customer's consent to acquire and process customer information. To provide performance of a contract to which the customer is party Bomaid might have to share the customers personal and sensitive data with authorized third parties such as service providers and consultants for processing. Our comprehensive privacy notice is available on our website.

I authorise Bomaid or any Bomaid contracted outsourced providers to collect, process and request my personal and sensitive data from any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information for any purpose directly related to our membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, also after the death or termination of membership of any of us.

I authorise Bomaid to deal with my dependants and me electronically and treat electronic communication (such as email, telephone, Bomaid's digital App) as being the same as written authority and confirmation. I agree further that, where we choose to use electronic methods to transact with Bomaid, we will carry the risk of such use.

Bomaid may use my information for the purpose of marketing (including direct marketing) of its suite of products, benefits and any other financial or non-financial services offered by itself and its subsidiaries.

I have the right to see any information that Bomaid holds about me, and to have my details removed.

I provide the consent of my own free will without any undue influence from any person whatsoever and I understand that I can withdraw my consent in writing at any time. The grounds for withdrawing consent should be legitimate, reasonable, and compelling.

The Fund may send your personal information to service providers outside Botswana for the storage or further processing on behalf of Bomaid. Bomaid will ensure to adhere to the provisions of the Data Protection Act before such transborder transfer of your personal information.

Signature \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---