

## CORPORATE MEMBERSHIP APPLICATION FORM

Membership Number

### 1. Principal Member: Your Personal Details

Attach copy of your ID or Passport. Application will NOT be processed without this document.

Specify date you want cover to start    Date of Birth

Title  First name (s)

Surname  ID/Passport No.

Male / Female  M  F  Nationality

Marital Status  S  M  D  Educational Background  Certificate  Diploma  Degree  Masters  PHD  Others

Home Phone  Cellphone 1

Work Phone  Cellphone 2

Preferred Email Address

Postal Address

Physical Address

### 2. Dependants (to be included in the membership)

Attach copy of your marriage certificate & spouse's certified copy of ID /Passport, birth certificates, Children's birth certificates or Police sworn affidavits (if you do not have your children's birth certificates ) if you are adding them as your dependants. Application will NOT be processed without these documents

1. Name Surname  Date of Birth     
ID/ Passport Number  Relationship to Main Member

2. Name Surname  Date of Birth     
ID/ Passport Number  Relationship to Main Member

3. Name Surname  Date of Birth     
ID/ Passport Number  Relationship to Main Member

4. Name Surname  Date of Birth     
ID/ Passport Number  Relationship to Main Member

5. Name Surname  Date of Birth     
ID/ Passport Number  Relationship to Main Member

Principal Member's Signature:



### 5. Applicant's banking details (For Claim Refunds)

Attach copy of principal bank letter confirming the below banking details. Application will NOT be processed without this document.

Applicant's full names

Applicant's Bank Name

Branch Name

Account Number

Account Type      **Current/Cheque**       **Savings**       **Credit Card**       **Transmission**

### 6. Next of Kin's Details

Full Names

Cellphone Number       Relationship to Main Member      Spouse       Son       Daughter       Parent       Other

Email Address       If Other specify:

## 7. Confidential Medical History

Please tick either **Yes** or **No** to each of these questions, Do you or any of your dependants have, or have you ever had any of the following? If you've indicated 'Yes' please state the condition below the respective question.

1.	Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attacks or other cardiac/vascular disorder?	Yes <input type="radio"/>	No <input type="radio"/>
2.	Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder?	Yes <input type="radio"/>	No <input type="radio"/>
3.	Nephritis, prostate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder?	Yes <input type="radio"/>	No <input type="radio"/>
4.	Diabetes, sugar in blood/urine, glandular, disorder, goitre or any other endocrine disorder?	Yes <input type="radio"/>	No <input type="radio"/>
5.	Conditions of joints or spine including rheumatism, arthritic, neck or back disorder?	Yes <input type="radio"/>	No <input type="radio"/>
6.	Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukaemia, skin cancer, lesion or any other related problems)?	Yes <input type="radio"/>	No <input type="radio"/>
7.	Ulcers (gastric or duodenal hiatus, hiatus cancer, lesion or any other related problems dysentery, gastro-intestinal or abdominal obstructions or any other related disorders)?	Yes <input type="radio"/>	No <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	Yes <input type="radio"/>	No <input type="radio"/>
9.	Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision tonsillitis, grommets', injuries, or any other ENT disorders?	Yes <input type="radio"/>	No <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?	Yes <input type="radio"/>	No <input type="radio"/>
11.	Expecting or planning to have a baby? If you have indicated 'yes' please state the expected delivery dates <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Yes <input type="radio"/>	No <input type="radio"/>
12.	Sexually transmitted diseases e.g syphilis. gonorrhoea, HIV /AIDS related illness or any other sexually transmitted diseases?	Yes <input type="radio"/>	No <input type="radio"/>
13.	Any physical disabilities or injuries?	Yes <input type="radio"/>	No <input type="radio"/>
14.	Any congenital disease/disability?	Yes <input type="radio"/>	No <input type="radio"/>
15.	Any special dental treatments e. crown bridge prosthodontic and orthodontic appliances or any other dental problems?	Yes <input type="radio"/>	No <input type="radio"/>
16.	Are you a smoker or routine user of alcohol and other narcotics?	Yes <input type="radio"/>	No <input type="radio"/>

## 8. Additional information

This section applies if you have indicated "Yes" to any questions in section 8.

	The relevant question number from section 8	When last did you see your doctor and for what reason?	Do you have any chronic conditions that may need medical attention within the next twelve months?	List details of medications used in the last twelve months and related conditions?
Principal Member				
1st Dependant				
2nd Dependant				
3rd Dependant				
4th Dependant				
5th Dependant				

## 9. Your doctors' details

Primary/Family Doctor

Email Address

Landline  Cell Number

### 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

**MEDICAL INFORMATION AND RECORDS RELEASE FORM:**

By signing this form, I authorize Bomaid to release details of my confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person/payee listed below:

Release my protected health information to the following person/payee:

Full Name

Postal Address

Home Phone  Mobile Number

The purpose/reason for this release of information is for the person/payee to know my medical condition as a family member and to enable him/her to take the necessary steps towards my health.

This authorization does not give authority to the above authorized person/payee to share my protected health information with anyone other person without my authority and consent.

This authorization is indefinite unless revised otherwise with another form.

Name of Authoriser

Signature of Authoriser  Date Signed

**How did you get to know about Bomaid?**

Social Media

Website

Employer

Print Media

TV

Family/Friends

Other

If Other specify:

Application Form Checklist

	Yes	No	N/A	Comments
Has the date when the customer want the cover to start been agreed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Certified copy of ID/Passport (Principal Member)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Copy of work permit and residence permit for non-citizens (Principal Member)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Postal Address provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Physical Address provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Proof of Address confirmation provided (Lease, utility or title deed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Confirmed details of dependants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Copy of ID/Passport for Spouse (If married)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Proof of Marriage (Marriage Certificate if married)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Copies of Birth Certificate(s) for Children/ Affidavit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Health Plan option confirmed with the customer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Actual Salary confirmed (if employed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Proof of Salary provided (Payslip or confirmation letter from employer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Certificate of membership provided (if been/covered elsewhere)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Banking Details provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Proof of Bank Account (Bank Statement/ Bank Letter)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Authorisation letter to deduct from account (if paying for someone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Confidential Medical History completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Additional Information provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
How did you get to know about Bomaid survey question answered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
KYC Form Completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Comments

Applicant Name

Applicant Signature  Date of Application

For official use only:

Date Signed  Agent Name

Comments

Signature

## KNOW YOUR CUSTOMER

Form last completed in

Membership Number

Individual Member

Corporate Member

Premium Payer

## IDENTITY DETAILS

Title  Full Name(s)

Surname  Nationality

Date of Birth

Omang / Passport Number

## ADDRESS AND CONTACT DETAILS

Postal Address

Physical Address

Village / Town / City  Country

Duration of stay  If less than 2 years give previous residential address

Telephone  Mobile

Fax  Email

Employer  Place of work

Occupation  Work Tel Number

## SOURCE OF INCOME/FUNDS/WEALTH

### Source of Income/Funds/Wealth:

Salary  Business income  Other income

If other specify:

### Salary verified by:

Payslip  Employment letter

### Business verified by:

Directors resolution  Confirmation of shareholding

### Other income verified by:

Relevant paying body e.g. confirmation from paying body e.g. trust/trustee, stockbroker, executor of estate



## BANKING DETAILS

Attach copy of principal bank letter confirming the below banking details. Application will NOT be processed without this document.

Applicant's full names

Applicant's Bank Name

Branch Name

Account Number

Account Type      **Current/Cheque**       **Savings**       **Credit Card**       **Transmission**

## ANTI-MONEY LAUNDERING AND COUNTER TERRORIST FINANCING REQUIREMENTS

In accordance with the Financial Intelligence Regulations the following documents should be provided for verification:

### Natural Persons

- Identification document e.g. certified copy of ID / Passport - work & residence permit for foreign nationals
- Source of funds / proof of income e.g. pay slip / bank statement / affidavit
- Proof of residence - Utility bill (not older than 3 months) / lease agreement or title deed / letter from employer / affidavit from Commissioner of Oath
- Birth Certificate - for medical aid taken under the name of a minor / child

## DECLARATION

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 Society 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 and explained to me.

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be liable for it.

Full name  Date

Place  Signature

**AFFIDAVIT CONFIRMING RESIDENTIAL ADDRESS**

I, the undersigned,

Name(s) of member  Full names as they appear on ID/Passport

ID No (Citizens)  Tobe filled out by citizens of Botswana

Passport No (Non-citizens)  To be filled out by non-citizen

Do hereby make oath that:

1. The content of this affidavit are within my personal knowledge, save where indicated, and the same are true and correct to the best of my knowledge and belief.

2. I am and adult female/male of full legal capacity residing at:

Physical address (Plot number, Street name/Kgotla/Ward (Fill out as appropriate))

and of postal address

3. I am currently employed by  Name of employer or Self Employed as

Job title/Position/Business done if Self Employed

4. I verify that the contents in this affidavit are true.

DEPONENT

Thus done and sworn to and signed before me at

this  day of  at  am/pm.

The deponent having acknowledged that he/she knows and understand the contents of this affidavit, adheres thereto, has no objection to taking the prescribed oath which he/she considers binding on his/her conscience. The provisions of the rules of the Commissioner of Oaths have been fully complied with.

COMMISSIONER OF OATHS