Once filled in please email the completed form and supporting documents to **newapp@bomaid.co.bw**

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INDIVIDUAL 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 D D M M Y Y Y Y   Date of Birth D D M M Y Y Y Y

Title   First name (s)

Surname   ID/Passport No.

Male / Female (Please tick where applicable) 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 D D M M Y Y Y Y
ID/ Passport Number   Relationship to Main Member

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

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

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

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

Principal Member's Signature:

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3. 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.

4. Applicant's banking details (Direct Debit authorization)

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

Payer's Full Names

Payer's Bank Name

Branch Name

Account Number

Account Type **Cheque** ◯ **Savings** ◯ **Credit Card** ◯ **Transmission** ◯

I / We hereby instruct and authorise Botswana Medical Aid Society to draw against my / account with the above named bank / our monthly subscriptions on the (circle / underline the desired debit date) 1st ◯ 7th ◯ 21st ◯ 28th ◯ day of each month commencing

and continuing until further notice in writing from me/us. All such withdrawal 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 adjustment 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.

Signature: Date Signed:

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

Email Address

Relationship to Main Member: Spouse ◯ Son ◯ Daughter ◯ Parent ◯ Other ◯

If Other specify:

7. How Long have you been without medical aid cover after the age of 35? (please attach proof of previous cover)

0 - 1 year ◯ 1 - 4 years ◯ 5 - 14 years ◯ 15 - 25 years ◯ 25 years or more ◯

**All members joining after the age of 35 with no previous cover or a gap in membership will incure a fee by way of additional premiums.*

8. 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 No
2. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder? Yes No
3. Nephritis, prostrate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder? Yes No
4. Diabetes, sugar in blood/urine, glandular, disorder, goitre or any other endocrine disorder? Yes No
5. Conditions of joints or spine including rheumatism, arthritic, neck or back disorder? Yes No
6. Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukaemia, skin cancer, lesion or any other related problems? Yes No
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 No
8. Nervous or mental complaint e.g. epilepsy convulsions, dizziness, blackouts, paralysis meningitis, anxiety states, depression, alcoholism meningitis, anxiety states, depression, alcoholism Yes No
9. Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision tonsillitis, grommets', injuries, or any other ENT disorders? Yes No
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 No
11. Expecting or planning to have a baby? If you have indicated 'yes' please state the expected delivery dates D D M M Y Y Y Y Yes No
12. Sexually transmitted diseases e.g syphilis. gonorrhoea, HIV /AIDS related illness or any other sexually transmitted diseases? Yes No
13. Any physical disabilities or injuries? Yes No
14. Any congenital disease/disability? Yes No
15. Any special dental treatments e. crown bridge prosthodontic and orthodontic appliances or any other dental problems? Yes No
16. Are you a smoker or routine user of alcohol and other narcotics? Yes No

9. 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				

10. 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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

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?				
Certified copy of ID/Passport (Principal Member)				
Copy of work permit and residence permit for non-citizens (Principal Member)				
Postal Address provided				
Physical Address provided				
Proof of Address confirmation provided (Lease, utility or title deed)				
Confirmed details of dependants				
Copy of ID/Passport for Spouse (If married)				
Proof of Marriage (Marriage Certificate if married)				
Copies of Birth Certificate(s) for Children/ Affidavit				
Health Plan option confirmed with the customer?				
Actual Salary confirmed (if employed)				
Proof of Salary provided (Payslip or confirmation letter from employer)				
Certificate of membership provided (if been/covered elsewhere)				
Banking Details provided				
Proof of Bank Account (Bank Statement/ Bank Letter)				
Authorisation letter to deduct from account (if paying for someone)				
Confidential Medical History completed				
Additional Information provided				
Medical Examination report provided (Members above 50 yrs)				
How did you get to know about Bomaid survey question answered				
KYC Form Completed				

Comments

Applicant Name

Applicant Signature

Date of Application D D M M Y Y Y Y

For official use only:

Date Signed

Agent Name

Comments

Signature

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KNOW YOUR CUSTOMER

Form last completed in D D M M Y Y Y Y   Membership Number

Individual Member   Corporate Member   Premium Payer

IDENTITY DETAILS

Title   Full Name(s)

Surname   Nationality

Date of Birth D D M M Y Y Y Y   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

BANK ACCOUNTS OF DEPENDANT DETAILS

Bank Name | Branch Name

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 D D M M Y Y Y Y

Place | Signature

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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 Emplyed
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