Once filled in please email the completed form and supporting documents to newapp@bomaid.co.bw OR fax to +267 3184152/ 230 OR drop off at your nearest Bomaid office

Bomaid
The medical aid you can trust

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	0	1	M	M	Y	Y	Y	Y	Date of Birth	D	D	M	M	Y	Y	Y	Y

Field		Field	
Title		First Name (s)	
Surname		ID/Passport No.	
Male / Female (Please tick where applicable)	M ◯ F ◯	Nationality	
Marital Status	S ◯ M ◯ D ◯ W ◯	Educational Background	Certificate ◯ Diploma ◯ Degree ◯ Masters ◯ PHD ◯ Others ◯
Home Phone		Cellphone 1	
Work Phone		Cellphone 2	
Personal Email Address			
Work Email Address			
Postal Address			
Physical Address			

2. Dependants (to be included in the membership)

Attach copy of your marriage certificate & spouse's ID /Passport, 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)		Date of Birth	D D M M Y Y Y Y
ID/ Passport Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent/ Parent in Law ◯
2)		Date of Birth	D D M M Y Y Y Y
ID/ Passport Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent/ Parent in Law ◯
3)		Date of Birth	D D M M Y Y Y Y
ID/ Passport Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent/ Parent in Law ◯
4)		Date of Birth	D D M M Y Y Y Y
ID/ Passport Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent/ Parent in Law ◯
5)		Date of Birth	D D M M Y Y Y Y
ID/ Passport Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent/ Parent in Law ◯
Principal Member's Signature			

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

Healthplan A ◯ Healthplan B ◯ Healthplan C ◯ Healthplan A Standard ◯

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

Attach copy of payer's bank statement OR 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	Current/Cheque ◯ Savings ◯ Credit Card ◯ Transmission ◯

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

Attach copy of principal member's bank statement OR 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	Current/Cheque ◯ Savings ◯ Credit Card ◯ Transmission ◯

6. Next of Kin's Details

Full Names			
Cellphone Number		Relationship to Main Member	Spouse ◯ Son ◯ Daughter ◯ Parent ◯
Email Address			

7. Confidential Medical History

Please tick either Yes or No to each of these questions, Do you have, or have you ever had any of the following? If you've indicated 'Yes' please state the condition below the respective question	Principal Member **Yes No**	1st Dependant **Yes No**	2nd Dependant **Yes No**	3rd Dependant **Yes No**	4th Dependant **Yes No**	5th Dependant **Yes No**
1. Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attacks or other cardiac/vascular disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
2. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
3. Nephritis, prostrate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
4. Diabetes, sugar in blood/urine, glandular, disorder, goitre or any other endocrine disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
5. Conditions of joints or spine including rheumatism, arthritic, 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 hiatus, hiatus cancer, lesion or any other related problems 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 meningitis, anxiety states, depression, alcoholism	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
9. Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision tonsillitis, grommets', injuries, or any other ENT 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? *If you have indicated 'yes' please state the expected delivery dates* D D M M Y Y Y Y	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
12. Sexually transmitted diseases e.g syphilis. gonorrhoea, HIV /AIDS related illness or any other sexually transmitted diseases?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
13. Any physical disabilities or injuries?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
14. Any congenital disease/disability?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
15. Any special dental treatments e. crown bridge prosthodontic and orthodontic appliances or any other dental problems?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯

8. 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 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

Doctor's name	
Email Address	
Landline	Mobile number

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 seven working days with or without birth certificate
Email copy of birth certificate to bomaid@bomaid.co.bw OR membership@bomaid.co.bw

Adding a spouse: Please attach a copy of your marriage certificate and copy of ID/Passport.

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
- [ ] Family/ Friends

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 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.

Signature		Date signed	D	D	M	M	Y	Y	Y	Y

FOR OFFICIAL USE ONLY

Date Signed	D	D	M	M	Y	Y	Y	Y	Received by	
Comments										
Signature										