NEW MEMBER APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE
Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

***Please complete in block letters, tick appropriate blocks unless otherwise indicated**

Botswana has implemented a law known as the Financial Intelligence Act and its Regulations, to combat money laundering (and other financial crimes), which is the abuse of financial systems to hide and/or disguise the proceeds of crime. In terms of this Act and its Regulations, BPOMAS is required before establishing a business relationship or carrying out a transaction, to obtain and verify, at a minimum, a prospective customer's identity, address and source of funds.Please play your part as a member to assist us in complying with these customer due diligence obligations by completing this form and submitting the attachments listed below.

WHY JOIN BPOMAS

As the market leading medical aid scheme in Botswana, we offer you the most affordable medical aid options to suit your individual and family needs, through industry-leading coverage and affordable monthly premiums.

Requirements
- The form must besigned and stamped by your employer

Attachments
- Copy of certified valid identification documents (Omang for citizens & passport for foreign nationals)
- Recent payslip (not older than 3 months)
- Spouse's certified ID copy and marriage certificate (if adding spouse)
- Children's certified birth certificates (if adding children)
- Certificate of membership from previous medical aid (if any)
- Proof of Address (Confirmation letter/Affidavit)

SECTION 1: SELECT YOUR HEALTH PLAN

Standard Benefit **Up to P30, 000 Cover** ☐	High Benefit **P315, 000 Cover** ☐	Premium Benefit **P500, 000 Cover** ☐
• No 10% Co-Payment	• 10% Co-Payment	• 10% Co-Payment
• Limited Hospitalisation Cover	• Comprehensive Hospitalisation Cover	• Comprehensive Hospitalisation Cover
• No Chronic and Dread Disease Cover	• Chronic and Dread Disease Cover	• Chronic and Dread Disease Cover
• P5, 000 Funeral Benefit Cover	• P10, 000 Funeral Benefit Cover	• P12, 500 Funeral Benefit Cover
• 24Hr Emergency Medical Services	• 24Hr Emergency Medical Services	• 24Hr Emergency Medical Services
• Premium Waiver (6months)	• Premium Waiver (6months)	• Premium Waiver (6months)
• 24Hr Mental Health Assistance	• 24Hr Mental Health Assistance	• 24Hr Mental Health Assistance
	• Wellness Benefit	• Wellness Benefit

SECTION 2: DETAILS OF PRINCIPAL MEMBER

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname ☐

First Name(s) ☐ Sex M ☐ F ☐ Date of Birth d d m m y y y y

Payroll Number ☐

ID or Passport Number ☐ Nationality ☐

Email ☐

Cell ☐ Tel (H) ☐ Tel (W) ☐

Postal Address	
Physical Address	

SECTION 3: ABOUT YOUR SPOUSE (only complete if adding spouse)

Title ☐ Initials ☐ Surname ☐

First Name(s) ☐ Sex M ☐ F ☐ Date of Birth ☐

ID or Passport Number ☐ Nationality ☐

Cell ☐ Tel (H) ☐ Tel (W) ☐

Email ☐

SECTION 4: ABOUT YOUR CHILD DEPENDANTS (only complete if adding Children)

First Name & Surname(s) attach certified copy of Child's Birth Certificate	Birth Dates D D M M Y Y Y Y	Gender	Identity Number/Birth Certificate or Passport Number

IMPORTANT - Failure to complete all information and attached document required will delay processing of membership. Failure to disclose material information or provision of incorrect information can result in the immediate cancellation of membership.

SECTION 5: YOUR MEDICAL AID HISTORY

Name of Previous Medical Scheme/s	Date Joined	Date Left

SECTION 6: YOUR EMPLOYMENT INFORMATION

Name of Employer

Occupation | Basic Salary **P** | Date of Employment (d d m m y y y y)

Employer Warranty

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.
Botswana Public Officers' Medical Aid Scheme may bill us for the amount due for this member in the same way as it does for our other employees with Botswana Public Officers' Medical Aid Scheme (BPOMAS).

Name

Designation

Email

Telephone

Postal Address

EMPLOYER'S STAMP

Authorised Signatory:_____

SECTION 7: BANK DETAILS OF PRINCIPAL MEMBER

Please note: we can not accept credit card account details

Bank Name | Branch Name

Branch Code | Account Number

Account Type Current ☐ Savings ☐

SECTION 8: MEDICAL HISTORY & GENERAL HEALTH INFORMATION

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

OPTIONAL DISCLOSURE

With specific reference to and acknowledgement of the details contained in the Medical Details below, failure to disclose the chronic and dread disease or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion.

(please supply the required information by marking the relevant box with an **X**)

1.	Do you or any of your dependants use chronic medicine?	Yes	No
2.	Disorders or problems with heart or cadiovascular system, e.g heart murmur, high blood pressure, high cholestrol, shortness of breath, palpitations, chest pains, angina, heart attack and/or other cardiac or blood disoders.	Yes	No
3.	Respiratory or lung disorders, e.g tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitus or allergic rhinitis.	Yes	No
4.	Disorders in the digestive system, stomach, gall bladder, pancrease or liver, e.g gastric or duodenal ulcers, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure or have you ever had a gastroscopy or colonoscopy?	Yes	No
5.	Diseases or disorders of the kidneys, bladder or reproductive organs, e.g abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted diseases.	Yes	No
6.	Disorder of the nervous system or brain, e.g epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease, or have you or any of your dependants been advised to have an MRI or CT scan?	Yes	No
7.	Mental disorders, e.g depression, anxiety, panic attack, schizophrenia, eating disorders, attention deficit hyperactive disorder (ADHD), or post -traumatic stress disorder.	Yes	No
8.	Ear, nose, throat or eye disorders, eg defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies.	Yes	No
9.	Disorders or diseases of the skin, muscles, bones, joints, limbs or spine, e.g any skin rash, arthritis, gout, fibromyalgia, any back, neck, hip, knee or other joint trouble, multiple sclerosis, any joint problems, or replacements, acne, eczema or psoriasis?	Yes	No
10.	Diabetes, thyroid or other glandular or blood disorders, e.g anaemia bleeding disorders, growth disorder, cushing's disease or Addison's disease.	Yes	No
11.	Cancer, a growth or tumor of any kind including moles removed (malignant/benign).	Yes	No
12.	Are you or any of your dependants currently undergoing or anticipating any specialised dental, maxillofacial treatment?	Yes	No
13.	Have you or any of your dependants had any accidents (including motor vehicle accidents)? If yes; confirm injuries sustained in accident and if there is any temporary or permanent injuries, and if you require any current of future treatment.	Yes	No
14.	Are you or any of your dependants taking ongoing medicine for any conditions not listed in any other of the questions?	Yes	No
15.	Have you or any of your dependants had any surgical procedure?	Yes	No
16.	Are you or any of your dependants awaiting or planning any operation or admission to any hospital in the next 12 months?	Yes	No
17.	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months?	Yes	No
18.	Gynaecological disorders, e.g abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormalities of pregnancy.	Yes	No
19.	Are you or any of your dependants pregnant? If so, what is the expected date of delivery? Date: _____	Yes	No

LATE JOINER PENALTY

Any applicant who is fifty (50) years of age or older who was not a member of one or more medical schemes at the time of joining the Scheme will incure a penalty by way of additional contributions as per Scheme rules as follows;

Years member was not a member of medical aid since the age of 50	Late joiner penalty
1-4 years	1.25
5-14 years	**1.5**
15-24 years	1.75
25 years +	**2**

DISCLAIMER

Please note that the following exclusions and waiting periods may be applicable as prescribed by the Scheme:

- 2 years for pre-existing Chronic Medical Condition(s),
- 1 year for limited Dentistry,
- 9 months for maternity and
- 3 months for an infant child registered after 30 days of birth or adoption.

If your answer was yes to any of the above questions, please provide full particulars in the next page. Please use a separate sheet of paper if the space provided is not enough.

Name of Person Suffering from the Illness	Question Number	Name of the Condition	Date Diagnosed	Name of Medication	Date of last Treatment / Medication	Date of Last Symptoms	Attending Doctor

SECTION 9: NOMINATION OF FUNERAL BENEFIT PAYOUT

In the event that the principal member passes on, the person named below will be legible to claim for the funeral benefit payout.

Surname	
Name	
ID Number	
Contacts	
Address	
Relation	

SECTION 10: DECLARATION

Failure to disclose material information is fraud. The provision of false, incorrect or incomplete information can result in the immediate cancellation of your membership.

Failure to disclose material information is fraud. The provision of false, incorrect or incomplete information can result in the immediate cancellation of your membership.

I the undersigned, hereby make application to the Administrator to be admitted as a member of the Scheme, and I agree to abide by the Rules of the Scheme. I declare that any false statement in the above questionnaire or the non-disclosure of any material information will render my membership null and void. I warrant that the above answers are true, correct and complete in every respect. I hereby authorise my employer to deduct from my salary each month the specified contribution and indebtedness to the Scheme and pay the Scheme on my behalf. I confirm that I am employed by the Employer in a full time capacity. I undertake to advise BPOMAS and its Administrator of any change in my state of health or that of my dependants which occurs prior to my receiving written acceptance of this application.

In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission, dissemination of such information in line with the Scheme services.

Signature of Member: _____ Date: _____

SECTION 11: BPOMAS COMMITMENT

The Scheme is committed to ensuring compliance with the Data Protection Laws of Botswana and that the information collected is used only for the purpose intended.

SECTION 12: CONSENT TO RECEIVE SCHEME UPDATES & MARKETING MATERIAL

I consent to receive Scheme updates and Marketing BPOMAS products, benefits, promotions and rewards. This can be perfomed through:

Email ☐ SMS ☐ Phone ☐ Postal Adress ☐

Signature of Member: _____ Date: _____

SECTION 13: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

Data protection is a matter of trust and your trust is important to us. We respect your right to confidentiality and privacy and, we are committed to complying with the Data Protection Act. The protection and the lawful collection, processing and use of your personal data is therefore an important concern for us in the provision of our services to our members.

SECTION 14: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

14.1 Acknowledgement

I hereby expressly acknowledge that the processing off my Personal Information and/or Special Personal Information and/or of my dependants by BPOMAS ("collectively referred to as "Personal Information"), as defined in terms of the Data Protection Act of 2018 (DPA). I acknowledge that;

14.1.1 I have read and understood the provisions of BPOMAS's Data Protection and Privacy Statement, thereby fully appreciating the manner in which BPOMAS may process my Personal Information and for which purpose(s) BPOMAS may process such Personal Information.

14.1.2. Through submitting this application, I am providing BPOMAS with the Personal Information of my spouse, child(ren) and/or other dependants (where applicable) and that engaging with BPOMAS through any physical and/or electronic means, BPOMAS will in effect be processing the Personal Information provided by me from time to time.

14.1.3 BPOMAS may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.

14.1.4 I fully appreciate that BPOMAS will only process my Personal Information and/or that of my dependants in a manner consistent with the provisions of the Data Protection Act, as well as for the purpose(s) set forth therein.

14.1.5 In accordance with the provisions of Section 28 of DPA, I have been provided with adequate notification of the processing of my Personal Information by BPOMAS, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so, and to request for access/destruction of my Personal Information that is held by BPOMAS.

14.1.6 I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

14.1.7 I have read and understood the undertakings made by BPOMAS in its Data Protection and Privacy Statement to the effect that it will ensure that any and all of Personal Information shall be processed with a reasonable standard of care as may be expected from BPOMAS.

14.2 Consent

In light of the above acknowledgements, and in accordance with the requirements set forth in Section 20 of Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information and that of my dependants (where applicable) for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:

14.2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.

14.2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the BPOMAS.

14.2.3 To facilitate the delivery of products and/or services to me as a member of BPOMAS to administer my claims and premiums.

14.2.4 To activate my medical aid and/or prescribed benefits to allocate a unique identifier (membership number) to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.

14.2.5 To transact with suppliers and business partners, including healthcare service providers, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.

14.2.6 To provide me with health and wellness information throughout the subsistence of my membership.

14.2.7 To transact with third parties and transfer my Personal Information (locally or across border) to such third parties for the purpose of enabling BPOMAS to fulfil its legitimate pursuit of contractual obligations towards me and within the requirements of the Data Protection Act.

14.2.8 To analyse and profile my Personal Information collected for research and statistical purposes.

14.2.9 For general administration purposes pertaining to my membership.

14.2.10 In as far as I provide BPOMAS with the Personal Information of any third party, including my spouse(s), children or other dependants (where applicable), I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of DPA.

Signature of Member: _____ Date: _____

SECTION 15: NEW MEMBER APPLICATION FORM CHECKLIST

NB: Members will be subjected to sanctions Screenings and Anti-Money Laundering/Combatting Financing of Terrorism & Proliferation (AML/CFT &P) control measures as required by applicable legislations.

	Yes	No
Certified copy of Omang (Passport for foreign nationals)	☐	☐
Copy of Payslip or Confirmation Letter Stating Basic Salary	☐	☐
Prof Of Residential Address (Confirmation Letter/Affidavit)	☐	☐
Certified copy of Omang and Marriage Certificate (if adding spouse)	☐	☐
Certified copies of Birth Certificates (if adding children)	☐	☐
Certificate of Previous Medical Aid Cover (if any)	☐	☐

AFFIDAVIT CONFIRMING RESIDENTIAL ADDRESS

ADMINISTRATORS OFFICE GABORONE

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The Field Precinct, CBD
Premium Box 625 AAH, Gaborone
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Tel: +267 316 8902
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BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

***Please complete in block letters, tick appropriate blocks unless otherwise indicated**

I the undersigned,

Name(s) of Member _____

ID No (citizens) or Passport No (Non-citizens) _____

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 an adult of full legal capacity residing at: _____ and of postal address _____

3. 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 _____

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 (name)

_____
Commissioner of Oaths (signature)

Stamp