

# APPLICATION FOR MEMBERSHIP FORM B I

I hereby apply for admission to membership of the Botswana Medical Aid Society. I confirm having read and understood the Society's rules and agree to accept and be bound by the rules.

**PURPOSE OF THIS APPLICATION** (Tick where applicable)

**SCHEME CHOICE** (Select preferred scheme option & refer to benefit/subscription schedule for guidance)

A	<input type="checkbox"/>	B	<input type="checkbox"/>	C	<input type="checkbox"/>	DS	<input type="checkbox"/>	DH	<input type="checkbox"/>	DN	<input type="checkbox"/>
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New member	<input type="checkbox"/>
Change of employer	<input type="checkbox"/>
Change to individual membership status	<input type="checkbox"/>
Membership number	<input type="text"/>

FOR SCHEME DS AND DH APPLICANTS ONLY		
ADD-ON BENEFIT OPTIONS	Single	Family
Optical overall cover	<input type="checkbox"/>	<input type="checkbox"/>
Dental overall cover	<input type="checkbox"/>	<input type="checkbox"/>
Funeral cover	<input type="checkbox"/>	<input type="checkbox"/>
Rehab Therapy overall cover	<input type="checkbox"/>	<input type="checkbox"/>
Appliances overall cover	<input type="checkbox"/>	<input type="checkbox"/>
Alternative treatments cover	<input type="checkbox"/>	<input type="checkbox"/>

FOR STUDENT SCHEME (DN) APPLICANTS ONLY			
PAYMENT OPTIONS			
Monthly	<input type="checkbox"/>	Direct debit	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	Monthly cheque	<input type="checkbox"/>
Annually	<input type="checkbox"/>	To be Paid IN by:	Student <input type="checkbox"/>
			Parent/guardian <input type="checkbox"/>
DETAILS OF PARENT/GUADIAN RESPONSIBLE FOR STUDENT'S SUBSCRIPTIONS PAYMENT			
Surname	<input type="text"/>		
First name	<input type="text"/>		
Employer	<input type="text"/>		
Address	<input type="text"/>		
Telephone no.	<input type="text"/>		
Signature of parent/guardian	<input type="text"/>		

## PERSONAL DETAILS

Principal member Surname	<input type="text"/>			Date of birth			Nationality					
First Names (In full)	<input type="text"/>			IDENTITY NUMBER			Marital status		M	S	D	W
POSTAL ADDRESS	<input type="text"/>						Gender		Male	Female		
Home Phone.	<input type="text"/>	Work Phone.	<input type="text"/>	CELL phone	<input type="text"/>	EMAIL ADDRESS	<input type="text"/>					
Dependant Names				Relation to member		Dependent ID NUMBER		Date of birth				
1.												
2.												
3.												
4.												
5.												
A completed <b>MEDICAL HISTORY FORM (B3)</b> for each member of the family (including principal member) must accompany this form						MEMBER'S SIGNATURE		<input type="text"/>				

## EMPLOYMENT DETAILS

 (new companies should enclose a copy of their certificate of incorporation)

Name Of new OR current employer			Date of employment:			Position Held		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
NAME OF PREVIOUS OR CURRENT MEDICAL INSURER	COVER PERIOD		FROM	TO	Please enclose an original certificate if cover was longer than two years consecutively, and has not ended later than three months ago.			
	<input type="text"/>		<input type="text"/>	<input type="text"/>				
TICK APPLICABLE SALARY GROUP ON YOUR PREFERRED SCHEME	SCHEME A		SCHEME B		Authorised Company representative signature/stamp:			
	P0-P1500		P0-P2299					
	P1501-P2299		P2300-3199					
	ABOVE P2299		P3199-P6200					
		ABOVE P6200						

**MEDICAL HISTORY FORM B3**

PRINCIPAL MEMBER	NEW DEPENDENT	ADDITIONAL DEPENDENT	
		MEMBERSHIP NUMBER	

Surname.....First names (in full).....

Gender.....Date of birth.....

Age next birthday.....Relationship to principal member .....

**DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**      **CIRCLE ANSWER**      **IF YES GIVE FULL DETAILS INCLUDING DATES**

1. Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attack or any 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, prostate 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, arthritis neck or back disorder?      YES/NO      .....
6. Any lumps, growths (benign or or malignant), cancer, Hodgkin's disease, leukaemia, skin cancer, lesion or any other related problems?      YES/NO      .....
7. Ulcers (gastric or duodenal hiatus-hiatus hernia) gall bladder problems, hepatitis, dysentery, gastro-interestinal or abdominal obstructions or any other related disorders?      YES/NO      .....

**(PLEASE TURN OVER)**

**FORM B3 (MEDICAL HISTORY) CONTINUED.....**

- 8. Nervous or mental complaint e.g. epilepsy, convulsions, dizziness, blackouts, paralysis, meningitis, anxiety states, depression, alcoholism, narcotism or any other related disorders ? 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? state the dates YES/NO .....
- 12. Sexually transmitted diseases e.g. syphilis, gonorrhoea, HIV /AIDS related illnesses 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.g. crown, bridge, prothodontic and orthodontic appliances or any other dental problems? YES/NO .....

- 16. When last did you see your doctor and for what reason?  
 .....
- 17. Do you have any chronic conditions that may need medical attention within the next twelve months?  
 .....
- 18. List details of medications used in the last twelve months and related conditions  
 .....  
 .....
- 19. State the name of your usual Medical Officer or any other Practitioner you have consulted to whom reference may be made.  
 .....  
 .....

I hereby declare that the particulars given above are, to the best of my knowledge true and correct;  
 Applicants Signature.....Date.....

**NEW COMPANY MEMBERSHIP REGISTRATION FORM B6**

*(This form must be accompanied by a copy of your company's CERTIFICATE OF INCORPORATION as well as the member application forms for your employees)*

Attach and complete the following details;

<b>NAME OF COMPANY</b>	
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<b>POSTAL ADDRESS</b>	
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<b>PHYSICAL ADDRESS</b>	
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<b>TELEPHONE/FAX</b>	
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<b>E-MAIL</b>	
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<b>NUMBER OF EMPLOYEES</b>	
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<b>NAME OF HUMAN RESOURCES MANAGER</b>	
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<b>NAME OF FINANCE MANAGER</b>	
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<b>NAME OF STAFF REPRESENTATIVE</b>	
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<b>DO YOU WISH TO COLLECT YOUR MAIL OR HAVE IT MAILED TO YOU?</b>	
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<b>SIGNATURE</b>	
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<b>DESIGNATION</b>	<b>DATE</b>	
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