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

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CHRONIC AILMENT FORM

Membership Number

1. Your Details Of Cover - Level Of Cover (Please tick one box only)

ISS (Student) ○ Access ○ Comprehensive ○ Executive ○ Prestige ○

Select your level of cover

Core ○ NB-core has no chronic cover Plus ○ Extra ○ Max ○

2. Principal Member Details - To be completed by the principal member

First name (s) Date of Birth D D M M Y Y Y Y

Surname ID/Passport No.

Male / Female (Please tick where applicable) M ○ F ○ Nationality

Home Phone Cellphone 1

Work Phone Cellphone 2

Preferred Email Address

Postal Address

Employer

3. Patient Details - Please provide details of the patient who requires the medication

Dependent Patient Names Contact Number

Male / Female (Please tick where applicable) M ○ F ○ D D M M Y Y Y Y

I hereby give consent that this application for chronic medication be given to BOMAID to perform drug utilisation review (DUR) if this service is provided for the sole purpose of enhancing my medical benefit. I understand that BOMAID needs to access personal clinical information in order to make informed recommendations regarding my chronic medication. I therefore authorise any medical service provider in possession of any medical information regarding myself or any of my dependants to provide BOMAID sufficient information that they may require, excluding any information which i stipulate in writing to my medical service provider. I acknowledge that my medical service provider retains responsibility for my treatment and diagnosis.

I hereby certify that the information provided on this application form is correct and I understand the terms of this application. I also understand that my participation is subject to my eligibility under the Medical Society.

Generic medication can significantly reduce prescription costs, while proviiding similar medical effect. Should there be a equivalent available (after agreement with yourDoctor) would you be prepared to use generic product? Yes ○ No ○

Signature Principal Member

Date Signed D D M M Y Y Y Y

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4. Medical Practitioner's Details - To be completed by the attending Medical Practitioner

First name (s)

Surname

Home Phone

Work Phone

Speciality

Botswana Practice Number

Email 1

Email 2

5. Condition and Medication Details - To be completed by the attending Medical Practitioner (1 form per patient)

Patient name

First name (s)

Surname

Chronic Condition	ICD 10 Code	Medication prescribed (State strength, dosage & quantity)	Allergies	How long has the member been on this medication		How many repeat prescriptions would you like your patient to receive (months)				
1				Years	Months	3	6	9	12	>12 Other
2										
3										
4										

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6. Clinical Information - To be completed by the attending Medical Pratitioner

General

Weight ____ kg Height ____ cm

Blood Pressure ____ mm/Hg Hb1Ac---

Smoker Y ☐ N ☐ No per day ____

Stress Level Mild ☐ Moderate ☐ Severe ☐

Exercise Mild ☐ Moderate ☐ vigorous ☐

Please specify type of exercise: ____

Patient History		Description	Family History	
Y ☐	N ☐	Heart Disease	Y ☐	N ☐
Y ☐	N ☐	Previous Myocardial Infarction	Y ☐	N ☐
Y ☐	N ☐	Other Major Ailments	Y ☐	N ☐

Please specify other ailments: ____

Medical Practitioner's Member ____

Date Signed D D M M Y Y Y Y

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