

TRAVEL APPLICATION FORM

Membership Number

1. Please Fill In Your Personal Details

- Ensure to write your names as they appear on your passport
- Note that the maximum number of travel days covered per dependant is 90 day per annum/year
- Maximum age limit for travel insurance cover is 80 years old

2. Please Indicate Your Health Plan

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:

Extra

Max

For more information, please refer to Health Plan booklet or enquire from Bomaid Sales personnel.

Section A: Principal Members Details

Title First name (s)

Surname Date of Birth

Email Address Passport No.

Section B: Travel Details

Date of Departure Date of Return

Departure Country Destination Country

Section C: Travelling Dependants Details

Title First name (s)

Surname Date of Birth

Passport No.

Title First name (s)

Surname Date of Birth

Passport No.

Title First name (s)

Surname Date of Birth

Passport No.

Section D: Member Declaration

I understand that, to assess my application and provide the requested travel insurance coverage, BOMAID is required to collect, process, and share my personal information (including special categories of personal data such as health and medical information, travel details, and financial information) with the insurance company/underwriter that underwrites and issues the policy ("the Underwriter")

I acknowledge that:

The processing and sharing of my personal information is necessary for the performance of the insurance contract (or to take steps at my request prior to entering into the contract) in terms of Section 26(b) of the Data Protection Act (No.18 of 2024).

Where special categories of personal data (in particular health data) are processed, this is done under Section 30(2)(b) of DPA and or other applicable exemptions available to insurance undertakings.

The Underwriter (or its authorised representatives) may contact me directly by telephone, email, text message, or post in connection with the underwriting, issuance, administration, claims handling, or servicing of this policy.

I confirm that the information I have provided is true, accurate, and complete to the best of my knowledge.

I have read and understand the above statement: **Yes**

Principal Member's Name

Principal Member's Signature

Date signed

Please fill out this form if you intend to seek medical services while outside Botswana

NOTE:
All emergency medical services accessed while travelling outside Botswana will be covered by the Travel Insurance. Please refer to your travel insurance policy document for more information how to submit those claims.
You may fill out this form and email it to bomaid@bomaid.co.bw before you access non-emergency medical services while outside Botswana
The following are services for which pre-authorization must first be sought before treatment: Hospitalization, Specialized radiology (CT, MRI, Nuclear medicine, PET scans), Appliances, Chemotherapy and Radiation therapy, Renal dialysis, Specialised dentistry, Orthodontic treatment. Requests for pre-authorisations must be emailed to casemanagement@bomaid.co.bw

Name Of Principal Member Membership No.

Patient Name	Membership No.	Type of service e.g. maternity delivery/ dental services/ optical services	Expected Date of service	Country of service
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Main Member's Signature

Date signed