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

International Student Healthplan Application Form

Specify the date you want your cover to start	0	1	M	M	Y	Y	Y	Y

Membership No.									

Section A - Institution Details

Attach admission letter from the institution for the applicant. Application will NOT be processed with out this document.

Name of Institution	
Educational Stage *(Please tick where applicable)*	Pre School ◯ Primary ◯ Secondary ◯ Tertiary ◯
Student Number	

Section B - Principal Member's Details

Attach copy of applicant's birth certificate (for pre schoolers and primary school students) OR ID/Passport copy for students 16 years of age and above. Application will NOT be processed with out these documents.

Surname				
First Name(s)		Male / Female *(Please tick where applicable)*	M ◯	F ◯
Identity No.		Date of Birth	D D M M Y Y Y Y	
Passport No.		Nationality		
Postal Address				
Home Phone		Cellphone 1		
Work Phone		Cellphone 2		
Email Address 1				
Email Address 2				

Section C - Direct Debit Authorization Details

Attach copy of payer's bank statement or letter from bank confirming the bank details (to verify account ownership)

Payer's Full Names	
Payer's Bank Name	
Branch Name	
Account Number	
Account Type	Current/Cheque ◯ Savings ◯ Credit Card ◯ Transmission ◯

I / We hereby instruct and authorise Botswana Medical Aid Society to draw against my / account with the above named bank / our monthly subscriptions on the

(tick the desired debit date) *1st* ◯ *7th* ◯ *21st* ◯ *28th* ◯ *day of each month commencing.....*
and continuing until further notice in writing from me/us. All such withdrawal from my / our account shall be treated as though they have been signed by me/ us personally. I / We authorise Botswana Medical Aid Society to automatically update the monthly subscriptions due to member changes and annual subscriptions adjustment without the need to sign new debit order authorisation. This instruction may be cancelled by me / us by giving a 30 days notice in writing, sent by registered mail or delivered to the society's offices, but I / We understand that I / We shall not be entitled to any refund of amounts which the Society may have already withdrawn while this authorisation was in force, if such amounts were legally owing to the Society. Receipt of this instruction by the Society shall be regarded as a receipt thereof by my / our bank.

Payer's Signature	

Date signed	D D M M Y Y Y Y

Section D - Next of Kin's Details

Surname			
First Name(s)		Identity Number/ Passport Number	
Relationship to Principal Member			
Email Address			

Section E - 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	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 expected delivery date **(SCHEME DOES NOT PROVIDE MATERNITY COVER)** 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?	○	○
16. Are you a smoker?	○	○

9. Your doctors' details

Doctor's Name	
Email Address	
Landline Number	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 days** with or without birth certificate

Email copy of birth certificate to **bomaid@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	Agent Name	
Comments			
Signature			