Pula Medical Aid Fund

Please complete in BLACK ink
Print clearly using CAPITAL letters
Only one character per block
Leave one block between words
Mark with an [X] where necessary

Administered by AFA Botswana (Pty) Ltd.

APPLICATION FOR THE REGISTRATION OF ADDITIONAL DEPENDANTS

AFA House
Plot 61918, Showgrounds
Office Park
P O Box 1212, Gaborone
Tel: 365 0500/365 0586
Fax: 395 1165

Autolot House
Plot 2074, Suite 104
Blue Jacket Street
P O Box 323, Francistown
Tel: 241 2290/241 2390
Fax: 241 2340

www.pulamed.co.bw

1.MEMBER DETAILS

(Please print all the information in blockletters ONE LETTER PER BOX)

Title: Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Others (Specify).....

Marital Status: Single ☐ Married ☐ Widowed ☐

Name of member Intials ☐☐

Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of Employer _____

Contact Address

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐ _____

_____

2. DETAILS OF DEPENDANT

Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

National Identity No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exemption Certificate No. (For expatriate) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth. Day ☐☐ Month ☐☐ Year ☐☐☐☐

Relationship to Member _____

Sex Male ☐ Female ☐

Total Monthly Income of Dependant P ☐☐☐☐☐☐☐☐☐☐

State if living with member Yes ☐ No ☐

State if member is fully responsible for medical express Yes ☐ No ☐

Previous Medical Aids _____ Membership No. _____

(Also attach certificates from previous medical aid scheme)

Note* Please complete the history section in respect of the above dependant except in the case of a new born (30 days) and ensure that the application is signed by the member overleaf.
*Attach copy of marriage certificate for spouse.
*Attach copy of certificate of membership.

_____
Signature of Employer

_____
Employer's Date Stamp

PLEASE COMPLETE REVERSE

3. MEDICAL HISTORY

Please give the name and address of the doctor or dentist your dependant may have recently consulted.

Doctor: _____

Dentist: _____

All question must be answered "YES" or "NO" by placing a "tick" in the adjacent block.		
3.1 Has the dependant ever been excluded from any benefit by any Insurance or Medical Aid Scheme?	YES	
	NO	
3.2 Has the dependant received any medical or orthodontical treatment during the last two years?	YES	
	NO	
3.3 Is the dependant suffering from, or has suffered from any chronic or recurring illness or any serious ailment?	YES	
	NO	
3.4 Is the dependant expecting to undergo any procedure, operation, confinement or receive any major dental treatment within the next 12 months?	YES	
	NO	
3.5 Is the dependant receving any treatment at present?	YES	
	NO	
3.6 Is the dependant receiving any prescribed medication of any nature at present, or within the last 12 months?	YES	
	NO	

If you have answered "YES" to any of the above questions please give full details below:

Question No.	Dates	Details

I, the undersigned, declare that the information provided in this application is true and correct and that any false statement or non-disclosure of any material information will render the application null and void.

_____ _____

Signature of Member Date