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.

CHANGE OF BENEFIT OPTION FORM
(To be received by AFA before 31 of December)

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

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

For Official Use only

GROUP | | | | | | | | | | | PAY POINT | | MEMBER TYPE | |

Section 1: TO BE COMPLETED BY MEMBER

NAME OF EMPLOYER _____

NAME OF MEMBER _____ SURNAME _____ DOB D D M M Y Y

SEX: Male ☐ Female ☐ TITLE: Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Others (Specify).....

MARITAL STATUS: Single ☐ Married ☐ Widowed ☐

Membership Number | | | | | | | | | | | ID No. | | | | | | | | | | | | | | |

ADDRESS: _____ TEL: BUS _____

_____ RES _____

_____

_____

Basic Monthly Salary _____ **Pay Roll No.** _____

	Name of Dependants Covered	Date of Birth	Relationship	ID No
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Option Selected: Standard Benefit Option ☐

De -luxe Benefit Option ☐

Please place a tick

Section 2: FOR OFFICAL USE ONLY

Processed By _____ Date _____

New Membership Number: | | | | | | | | | | |

Employers' Official Stamp

Signature of Member _____

Signature of Employer _____