Member Application Form

BOTSOGO HEALTH PLAN

METROPOLITAN HEALTH BOTSWANA

3rd Floor, Fairground Office Park, Plot No 50676, Meodi Street, Gaborone
Private Bag 00391, Gaborone, Botswana Tel: +267 3624700 Fax: +267 3190405

Requested Membership Date 0 1 M M Y Y Y Y OR
ON ACCEPTANCE X (Date determined by Scheme)

Brokerage

Broker Code

Employer

Branch

Branch Code

Employer Code *(office use only)*

Member No. *(office use only)*

Please select only one option: (Indicate with an "X" in chosen block next to option)

Bronze (outpatient)		**Copper option**		**Ruby option**		**Platinum option**		**Diamond option**	
Bronze (inpatient)		**Copper 10 option**		**Ruby 10 option**		**Platinum 10 option**		**Diamond 10 option**	
Bronze option									

CONTRIBUTION CALCULATION

		MONTHLY CONTRIBUTION	SUB TOTAL	SUB TOTAL
Main Member	1 X	P .	P .	**Debit order**
Adult Dependant		P .	P .	**Employer deduction**
Child Dependant		P .	P .	
Monthly Savings Amount (MSA)			P .	
TOTAL MONTHLY CONTRIBUTION CALCULATION			P .	

PRINCIPAL MEMBER

Title **Initial(s)** **Registered First name**

Surname **Gender** M F **Smoking** Y N

ID no. **Weight** KG **Height** M

Pensioner Y N **Marital status** Single Married Divorced Widowed **Date of birth** (dd mm yyyy)

Monthly Salary P *Please attach a copy of your payslip (not older than 3 months)* **Employee/Payroll no.**

PRINCIPAL MEMBER ADDRESS *(Pease note: one telephone number is compulsory)*

Postal address

Town/city **Postal Code**

Residential address

Town/city **Postal Code**

Email address

Tel no. (h) (w) **Cell no.**

0 6 1 3 3

SPOUSE/PARTNER

Title		Initial(s)		Registered First name	
Surname		Gender	M F	Monthly Salary	P
ID no.		Weight	KG	Date of birth (dd mm yyyy)	

SPOUSE / PARTNER / CHILD & SPECIAL DEPENDANTS

(Complete special dependant form for mother, father, adopted/foster child, brother, sister or other relatives. Also complete special dependant form for children over the age of 21 years.)

An affidavit /legal supporting documentation is required for special dependants and/or dependents with different surname from Applicant

1.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
2.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
3.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
4.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
5.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
6.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
7.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		
8.	Surname		ID no.		
	Registered names		Date of birth (dd mm yyyy)		Gender M F
	Initial(s)		Relation		

MEDICAL HISTORY OF MAIN MEMBER AND DEPENDANTS

Any previous or current treatment for a disorder or condition must be disclosed and/or marked as YES. Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases. This section refers to main member and dependents.

Please circle the specific condition

EXAMPLE

Condition	Yes	No
Birth defects & inherited disorders - Spina Bifida, injuries, Heart Disorders or other.		

Condition	Yes	No
1. **Birth defects & inherited disorders** - Spina Bifida, injuries, Heart Disorders or other.	Y	N
2. **Dermatological** - Acne, Eczema, Pemphigus, Psoriasis, Fungal infections or other.	Y	N
3. **Musculo-Skeletal** - Osteo-arthritis, Rheumatoid arthritis, Osteo-sarcoma, Gout, Osteoporosis, Lupus Erythematosus or other.	Y	N
4. **Ear, Nose and Throat** - Deafness/Hearing impairment, Allergic Rhinitus, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disease or other.	Y	N
5. **Respiratory disorders** - Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Bronchiectasis or other.	Y	N
6. **Gastro-Intestinal** - Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Oesophageal reflux, Spastic Colon, Ulcerative Colitis, Malabsorbtion Syndrome or other.	Y	N
7. **Urological Disorders** - Chronic Renal Failure, Kidney Stones, Chronic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary incontinence, Urinary retention or other.	Y	N
8. **Neurological** - Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy or other	Y	N
9. **Psychiatric** - Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep disorders, Attnetion Deficit Hyperactivity disorder, Neurosis, Obsessive-Compulsive disorder or other.	Y	N
10. **Metabolic disorders** - Lipid Disorders, Porphyria or other.	Y	N

Condition	Yes	No
11. **Cardiovascular** - Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Hypercholesterolaemia, Aneurysm, Angina, Ischaemic Heart Disease, Peripheral Vascular or other	Y	N
12. **Liver and Pancreas Disorders** - Hepatitus, Cirrhosis, Gallstones, Pancreatitis, Chronic Cholecystitis or other.	Y	N
13. **Blood Disorders** - Anaemia, Leukemia, Haemophilia, Clotting Disorders, Thrombocytopenia or other.	Y	N
14. **Endocrine Disorders** - Diabetes Insipidus, Hypothyroidism, Hyperthyroidism, Addison's Disease, Cushing's Syndrome, Diabetes, Mellitus, Hypoglycemia or other.	Y	N
15. **Infections** - HIV, Hepatitis or any sexually transmitted disease	Y	N
16. **Cancer** - any form	Y	N
17. **Gynaecologist system** - Infertility, Endometriosis, Ovarian Cysts, Menopause, Menstrual disorders, Mastalgia or other.	Y	N
18. **Eye Disorders** - Impaired vision, Glaucoma, Retinopathy, other	Y	N
19. **Dental Conditions** - Surgery, crowns, bridges, braces or other	Y	N
20. **Have/are you being compensated for any disability?**	Y	N
21. **Are you or your partner pregnant or do you suspect you are?**	Y	N
22. **Any previous surgery?**	Y	N
23. **Any exclusions on previous medical aid?**	Y	N
24. **Are you on any other medical aid?**	Y	N

(Please use a separate page if more than two conditions)

Any other conditions 1)

2)

If YES to any of the previous questions please complete the section below, and fill in the applicable condition number:
(Please use a separate page if more information applies to relevant questions)

Condition No. **Patient** **Doctor**

Treatment **Last Date of treatment** (dd mm yyyy)

Condition No. **Patient** **Doctor**

Treatment **Last Date of treatment** (dd mm yyyy)

Condition No. **Patient** **Doctor**

Treatment **Last Date of treatment** (dd mm yyyy)

CURRENT CHRONIC MEDICATION *(Please use a separate page if more than three chronic medications are used)*

Initials **Registered First Name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

Initials **Registered First Name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

Initials **Registered First Name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

STATEMENT BY EMPLOYER CONCERNING PRINCIPAL MEMBER

I, _____ (responsible officer)

of _____ (name of employer)

hereby state that the applicant:

(a) has been employed since (dd mm yyyy) _____ (b) qualifies for membership (dd mm yyyy) _____

(c) as participating member under option

Bronze (outpatient)	☐	Copper option	☐	Ruby option	☐	Platinum option	☐	Diamond option	☐
Bronze (inpatient)	☐	Copper 10 option	☐	Ruby 10 option	☐	Platinum 10 option	☐	Diamond 10 option	☐
Bronze option	☐								

(d) gross monthly earnings P _____ Branch _____

(e) and has the personnel number of _____ Date (dd mm yyyy) _____

Signature (on behalf of the employer)

Employer Stamp

STATEMENT BY MAIN MEMBER

I, _____ hereby state that:

(a) Should I be enrolled as a member of The Scheme, I will subject myself to the rules of The Scheme. The information herein is completed true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to The Scheme, it is found that my statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to The Scheme all payments which The Scheme have made on my behalf and to relinquish any claim to any benefits on the part of The Scheme.

(b) Should there by any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by The Scheme for the commencement of membership or the date of acceptance of this application by The Scheme; or the date of receipt of the first contribution, (whichever date is the latest), The Scheme will be entitled to reconsider the application and propose new terms of admission or declare the membership null and void.

(c) Any monies paid to The Scheme in terms of this membership, before The Scheme is informed of the change, shall be forfeited and benefits paid by The Scheme, shall immediately be refunded to The Scheme.

(d) I am bound now, and in the future, if we (myself and my dependants) are accepted as members, to give The Scheme all such information and evidence to The Scheme as they require from time to time. I authorise the attending medical practitioner or any other provider, to provide The Scheme with such information as it may require, hereby waiving the provisions of any law or regulation restricting the giving of such information.

(e) I undertake to pay any other amount due to The Scheme, on default. I hereby authorise my employer to deduct the due amount from my salary or any other monies due by me.

(f) In the event of voluntary resignation from The Scheme, I agree to give The Scheme one calender month notice, which must be received by The Scheme in writing by no later than the 7th of the month.

(g) I agree to call The Scheme client services with regards to any queries and pre-authorise any treatment as required by The Scheme.

(h) The Scheme shall review all benefits, contribution and Scheme Rules on an annual basis. Members will be notified of any changes accordingly.

(i) The Scheme reserves the right of admission for membership to the Scheme.

Signature of Applicant _____ Date (dd mm yyyy) _____