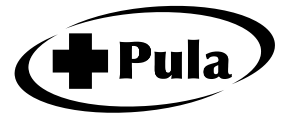
CHANGE OF BENEFIT OPTION



Medical Aid Fund

We care for your health!

PULA MEDICAL AID FUND Administered by Associated Fund Administrators Botswana (Pty) Ltd.
Gaborone: AFA House • Plot 61918 • P O Box 1212 • Gaborone • Botswana • Telephone: (+267) 365 0555 (Call center) / 365 0500 (Reception) • Fax: (+267) 395 1165
Francistown Branch: Baines Avenue • Plot 31966 • Unit 2 • Ground Floor • P O Box 323 • Francistown • Botswana • Telephone: (+267) 241 2390 / 241 2290 • Fax: (+267) 241 2340
www.pulamed.co.bw

***please complete in block letters, tick appropriate blocks unless otherwise indicated**
***please select an option you want to upgrade/degrade to:**

EXECUTIVE ☐ P2 Million Cover
DELUXE ☐ P1.2 Million Cover
GALAXY ☐ P100,000 Cover
STANDARD ☐ P40,000 Cover
FLEXI ☐ P60,000 Cover

About yourself (principal member)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ______ Initials ______ Surname ______

First name(s) ______ Sex M ☐ F ☐ Date of birth d d m m y y y y

Occupation ______

ID or passport number ______ Country of Issue ______

Membership number ______ Basic Salary P ______

Cell ______ Tel (H) ______ Tel (W) ______ Fax ______

Email ______

Postal Address ______ Village/Town ______ Physical Address ______

Note* Member may only transfer from one benefit to the other on the first day of the financial year provided he has given one(1) month written notice.

Your employment details

Name of Employer ______

Occupation ______ Date of employment d d m m y y y y

Employer warranty

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.
Pula Medical Aid Fund may bill us for the amount due for this member in the same way as it does for our other employees with Pula Medical Aid Fund

Name ______

Designation ______

Email ______

Telephone ______

Postal Address ______

EMPLOYER'S STAMP

Authorised signatory______ Signature of the Principal Member:______

Your banking details

Please note: we can not accept credit card account details

Bank name

Branch name Branch code

Account number Type of account Cheque ☐ Savings ☐

Account holder

By signing this application, you agree that claims will be refunded into the account you have chosen.

Signature of the Principal Member:____

***please attach a clear copy of your recent payslip (not older than two months)**

***please attach proof of account (bank statement/cancelled bank cheque)**

Nomination for funeral benefit payout

In the event that the principal member passes on, the person named below will be legible to claim for the funeral benefit payout.

Surname

Name

ID number

Contacts

Address

Relation