CONTINUING MEMBERSHIP APPLICATION FORM

pulamed
Hello Life

PULA MEDICAL AID FUND Administered by Associated Fund Administrators Botswana (Pty) Ltd
Gaborone Office: Plot 74769 • Mowana Mews Ground Floor, CBD • P O Box 1212 • Gaborone • Botswana • Telephone: (+267) 365 0555 (Call Center)
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***please complete in block letters, tick appropriate blocks unless otherwise indicated**

INDIVIDUAL MEMBER ☐ **CORPORATE MEMBER** ☐

Choose Option:
EXECUTIVE P2.3 Million Cover ☐ **DELUXE** P1.4 Million Cover ☐ **GALAXY** P125,000 Cover ☐ **STANDARD** P50,000 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

Occupation

ID or passport number Country of Issue
*attach certified copy of ID

Basic Salary P * attach recent copy of Pay Slip(not older than 2 months)

Cell Tel (H) Tel (W) Fax

Email

Postal Address Village/Town Physical Address

About your spouse (*only complete if adding spouse)

Title ☐ Initials ☐ Surname

First name(s) Sex M ☐ F ☐ Date of birth

Employer

ID or passport number Country of issue

Cell Tel (H) Tel (W)

Email

***attach copies of marriage certificate and spouse ID, if spouce was not previously covered About your dependants (only complete if adding child dependants)**

FAMILY MEMBERS TO BE COVERED

First Names & Surname(s) ***Attach child's birth certificate.** (If children were previously not covered)	Birth Dates	Gender	Identity Number/Birth Certificate or Passport Number
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

Effective date of Individual Membership

Date of joining the Fund

Current PULA Membership No:

IMPORTANT
Failure to complete all information and attached document required **will** delay processing of membership. Failure to disclose material information or provision of incorrect information **can** result in the immediate cancellation of membership.

I, _____*, acknowledge that I have read and understood the privacy notice attached hereto, or that the Pulamed/the administrator's client services officer has explained this privacy notice to me. I understand that the above personal data concerning me has been collected and will be used for the above stated purposes.

*Kindly note that the privacy notice is not a consent form but a notice to inform you, the data subject of the collection of your personal data by Pulamed.

Signature of Member: _____Date: _____

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

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

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

Signature of the Principal Member:_____

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

Your employment details (please complete only if changing company)

Name of Employer

Industry | Date of employment

Employer warranty (please complete only if changing company)

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:_____

SUBMIT FORM TO;
clientservices@afa.co.bw