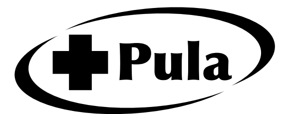
# CONTINUING MEMBERSHIP APPLICATION FORM




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**

**INDIVIDUAL MEMBER** ☐ **CORPORATE MEMBER** ☐

**Choose Option:** **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 ____
*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 d d m m y y y y

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 D | D | M | M | Y | Y | Y | Y | Gender | Identity Number/Birth Certificate or Passport Number |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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.

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 d d m m y y y y

## 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:______________________________________________