

TRAVEL INSURANCE INFORMATION FORM

Title

Surname

First Name(s)

Date of Birth Passport Number

Nationality

Physical Address

Postal Address

Contact Nos. Work Res Mobile

Membership Number

Travel Details

Departure Date Return Date

Destination

Name of the Doctor Tel. of Dr

Additional Members Information (if travelling with dependant)

Full Names	Date of Birth	Identity Number	Nationality

Terms and Conditions

By filling this form you accept the terms and conditions that govern the policy.

The application is subject to the Policy Wording Document and prevailing Pula Medical Aid Fund Rules which are subject to change without notification.

The Policy wording document is available for perusal at www.pulamed.co.bw/downloads.

For more information contact Sales & Marketing at 3650504/586 or marketing@afa.co.bw