

KNOW YOUR CUSTOMER FORM (FINANCIAL INTELLIGENCE ACT) FOR INDIVIDUALS

PULA MEDICAL AID FUND Administered by Associated Fund Administrators Botswana (Pty) Ltd.
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FORM LAST COMPLETED IN (MM/YR)

IDENTITY DETAILS

Title Name(s) Surname
Date of Birth National ID / Passport No.
Nationality Country of Origin
Related to PIP YES NO if yes, please state relationship

ADDRESS AND CONTACT DETAILS

Postal Address
Physical Address
Village / Town / City
Duration of stay if less than 2 years, state previous Country of residence
Telephone Mobile Fax
Email Address

SOURCE OF INCOME & BANKING DETAILS

Occupation Source of Income used for contributions
Bank Name Branch Account Number
Account Type

ANTI-MONEY LAUNDERING AND COUNTER TERRORIST FINANCING REQUIREMENTS

In accordance with the Financial Intelligence Regulations the following documents should be provided for verification:

SUPPORTING DOCUMENTATION

- The Following Supporting verification documentation should be provided:
- certified copy of Valid Identification Document (Omang for citizens and Passports for foreign nationals)
 - Proof of Residential Address (Utility Bill, Lease agreement, Title Deed, Letter from Kgosi, Affidavit)
 - Proof of source of income (payslip, letter of employer, bank statement)

DECLARATION

I hereby declare that the details furnished along with the attached supporting documentation are true and correct for the best of my knowledge and belief and I under-take to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be liable for it.

Full Name:
Date Place
Signature

SUBMIT FORM
aml@pulamed.co.bw