

TRAVEL INSURANCE PROPOSAL FORM

PULA MEDICAL AID FUND Administered by Associated Fund Administrators Botswana (Pty) Ltd
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www.pulamed.co.bw

Title (Mr/ Mrs/ Miss / Dr) Surname

First Names(s) Date of Birth

Medical Aid Number Passport Number Nationality
(For Pulamed members only)

Postal address

Physical Address

Email Address

Contact Nos. Work Res Mobile

Departure Date Return Date

Destination Beneficiary

Name of Doctor Tel No. of Dr

Additional Members Information *(Your Pulamed dependants travelling with you on this trip)*

Title	Full Names	Date of Birth	Passport Number	Nationality

Signature: _____

Date: _____

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