FIRST MUTUAL
HEALTH
Go Beyond

First Mutual Health: Plot 54354, Second Floor, Central Business District, Gaborone, Botswana. Web: www.firstmutualhealth.co.bw Email: ClientServices@firstmutualhealth.co.bw

MEMBERSHIP APPLICATION FORM

For administrative use

MEMBERSHIP NUMBER		PAYER NO.	
COMPANY NAME			

Section 1. CHOICE OF PLAN

PLAN	**Express Diamond**		**Express Platinum**		**Express Gold**		**Express Silver**	

Section 2. DETAILS OF PRINCIPAL MEMBER

TITLE	Mr		Mrs		Miss		Ms		Dr		Prof	
FIRST NAME(S)												
SURNAME												
GENDER	MALE				FEMALE							
MARITAL STATUS	Single		Married		Divorced		Widowed		Other			
ID NUMBER												
DATE OF BIRTH												
EMAIL												
POSTAL ADDRESS												
PHYSICAL ADDRESS												
CELL NUMBER												

Date from which membership is supposed to commence: _____/_____/_____

Section 3. DETAILS OF DEPENDANTS TO BE INCLUDED

Adult rates apply to any dependant who is 18yrs or older. Child rates apply from newly born babies to full time students aged 18-24yrs provided proof of education for the current year is attached to the application form. Acceptance of the dependants will be in accordance with the Rules of the Scheme.

SURNAME	FIRST NAME & INITIALS	DATE OF BIRTH	RELATIONSHIP	GENDER		ID NO.
				M	F	
				M	F	
				M	F	
				M	F	
				M	F	
				M	F	
				M	F	
				M	F	

Section 4. DECLARATION OF MEDICAL HISTORY

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all required information by inserting a tick in the relevant box. If the answer to any question is 'YES' provide details in section 5.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

			Y	N
1		**Have you or any of your dependants ever suffered from any of the following?**		
	1.1	High blood pressure, high cholesterol, or stroke?		
	1.2	Diabetes, thyroid or other glandular or blood disorder?		
	1.3	Any anomaly of the heart (e.g., heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?		
	1.4	Any respiratory or lung disorder (e.g., asthma, persistent cough, TB)?		
	1.5	Any disorder of muscles, bones, joints, limbs, spine (e.g., arthritis, gout, slipped disc or back issues)?		
	1.6	Any ear, nose, or throat disorder (e.g., ear discharge, poor vision, recurrent tonsillitis, chronic sinusitis, swollen glands), or any long-running eye disease (e.g., cataracts, short or long-sightedness)?		
	1.7	Any dysfunction of the kidneys, bladder, or reproductive organs (e.g., kidney stones, prostate issues, urinary incontinence, sexually transmitted infections) or gynaecology-related symptoms or conditions (i.e., problems with female organs)?		
	1.8	Any neurological or mental condition (e.g., epilepsy, migraine, blackouts, paralysis, anxiety disorder, panic attacks, or depression)?		
	1.9	Any disorder of the digestive system, gall bladder or liver (e.g., actual or suspected gastric or duodenal ulcer, recurrent indigestion, acid reflux, hepatitis B or persistent diarrhoea)?		
	1.10	Any lumps, growths, or confirmed cancers (including blood and skin cancers)?		
	1.11	Any sexually transmitted disease (e.g., hepatitis B, gonorrhoea, or syphilis)?		
	1.12	Any other condition, illness, disease, disability, or accident which required medical, dental, surgical, radiological, or laboratory investigations in the past 12 months?		
2		Have you or any of your dependents undergone, or are you or any of your dependants undergoing any surgical, medical, major dental (including implants), chiropractic, optical (spectacles) or gynaecological treatment, or investigations?		

3	Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap, or defect, whether from birth or because of an accident, disease, or some other cause?		
4	Do you or any of your dependants currently use medication on a daily basis?		
5	Are you or any of your dependants expecting to undergo any medical or surgical procedure, or receive any major dental treatment during the next 12 months?		
6	Are you and/or any of your dependants pregnant?		
	Name of person: Number of months pregnant:		
7	Has your weight or the weight of your dependants changed by more than 5kg over the last 12 months?		
8	Are there, pertaining to you or to your dependants, any other circumstances not mentioned elsewhere in this declaration relating to past or present diseases, accidents, operations, or other conditions (including pregnancy) for which treatment has been received or recommended during the past 12 months?		
9	Have any exclusions been imposed by any medical scheme on which you and your dependants have been registered?		
	If yes, please state the details:		

If you answered 'YES' to any of the questions above, please complete details in Section 5 in full.

Section 5. ADDITIONAL MEDICAL INFORMATION

Question number				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which illness began (or year)				
Frequency of attacks (hourly/daily/weekly/monthly)				
If hospitalised, when and for how many days				
Duration of illness or condition				
Treatment and/or type of medication received in the past	Treatment			
	Medication			
Current treatment and/or type of medication received	Treatment			
	Medication			
Approximate monthly cost of treatment/ type of medication	Treatment			
	Medication			
Details of operations previously performed				
Name of attending medical or dental practitioner				

Section 6. WAITING PERIODS AND PRE-EXISTING MEDICAL CONDITIONS

The Scheme reserves the right to impose waiting periods, i.e., a general waiting period of three months and/or a specific waiting period for a pre-existing condition, as defined in the rules.

Section 7. PREVIOUS MEDICAL INSURANCE (Please attach membership certificate showing termination date)

Name of Medical Aid Scheme	Plan/Package	Membership No.	Date of Registration	Date of Termination

Are you changing your medical aid due to change of employer? If yes, please provide a letter from previous employer confirming termination of employment and date.

Section 8. EMPLOYER/ACCOUNT HOLDER INFORMATION

This section MUST be completed by the Employer/Account holder. No application form will be processed without the Employer/Account holder authorisation signature or stamp.

Name of Employer/Account holder

Employer Account No._____ **Employee EC No.**_____

Medical Aid Start Date: _____ **Employment Date:** _____

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and Plan chosen. All sections of the application form have been completed.

Employer Telephone No. _____

Signature_____

Section 9. BANKING DETAILS FOR REFUNDS

Bank Name: _____

Branch Name: _____ Branch Code: _____

Name of Account Holder: _____

Bank Account Number: _____

Signature of Principal Member**:** _____ Date: _____/_____/_____

TERMS AND CONDITIONS ON APPLICATION FOR MEMBERSHIP

This form should be completed by first time applicants to First Mutual Health or if you were a dependant and now wish to be a member in your own right. If you are a member of First Mutual Health and wish to add or remove a dependant or change from one Plan to another, complete the Membership Update Form.

Please complete all the sections of this application form as it forms the basis for your registration.

Section 1 Choice of Plan

First Mutual Health offers a variety of Plans. Please tick the appropriate box for the Plan you wish to join. Your employer should approve the Plan choice if you are joining through a company.

Section 2 Details of Principal Member

The personal details of the principal member should be entered here. Settlement advice slips and cheque refunds will be made out to this person. Please enter the personal details as they appear on your identity document as you may be asked to produce this along with your membership card when you see providers of health services.

Section 3 Dependants

May include your spouse, your children, or in certain circumstances, other dependant the member wishes to benefit from the Scheme. The Scheme may request a medical report before accepting other family members as dependants. Relationship to member describes the relationship of the dependant to the principal member. Spouse and child are normal dependants anyone else e.g. parents, in-laws etc is considered to be an "other dependant". A child aged between 18 and 24 years may be classified as a student provided, they are studying full-time and proof of education for the current year is attached to the registration form. Otherwise, such a child will be classified as an "adult dependant".

All personal and medical information provided in respect of dependants will be used strictly for the purpose of determining eligibility, underwriting, and administration of benefits in accordance with the Botswana Data Protection Act.

Section 4 Declaration of Medical History

The medical information requested in this form is collected and processed solely for the purpose of assessing eligibility, administering benefits, and complying with legal and regulatory obligations under the Data Protection Act. The Fund will ensure confidentiality and process such data only by authorised personnel.

You need to inform the Fund, if you, or any of your dependants you are registering, is currently undergoing, or likely to require medical treatment. It is very important that you disclose all information as failure to do so will be a breach of contract leading to failure to have claims settled.

Section 5 Previous Medical Insurance

Please provide a membership certificate with termination date if you are moving from another medical aid Fund. If you are changing employer, please provide a letter confirming termination of employment and date.

Section 6 Employer /Account Holder Information

This section should be completed by the person who will be responsible for remitting your contributions to First Mutual Health either the Individual account holder, or your employer designated officer. Employers need to stamp the form and sign as authorisation for applicant to be on the First Mutual Health Scheme.

For avoidance of doubt, the employer's role is limited to facilitating the remittance of contributions on behalf of the member and does not imply any guarantee, liability, or responsibility for the member's medical expenses or obligations under the scheme.

The account holder number is the number which appears on the billing invoice. If you are applying for membership without Employer affiliation you should submit a completed Employer/ Individual Account Holder application form along with your membership application. The Employer account number is automatically generated by First Mutual Health, please remember to quote the number each time you remit your contributions.

Start date is the effective date from which the membership wants to be registered and benefit. Membership runs from the first day of the month to the last day of the month. Applications must be received before the 25th day of the month for registration to be effective from the following month.

Section 7 Banking Details of Principal Member

Please provide First Mutual Health with your banking details to enable the payment of claims refunds, savings pot or cash back through Electronic Funds Transfer (EFT).

Section 8 Cooling off period

New members will receive or may request a copy of the Scheme Rules upon registration. Members have up to one calendar month from the date of premium payment to terminate their membership if they do not agree with the Scheme Rules. Failure to terminate for more than one month will be taken as consent to become a member of the Fund based on the Scheme Rules.

Section 9: General Terms and Conditions

Any false statement, misrepresentation, or omission of material information in this application may result in rejection of membership, termination of cover, or forfeiture of benefits. The Fund reserves the right to recover any amounts paid out on the basis of false or incomplete information.

The Fund reserves the right to suspend or terminate membership where contributions remain unpaid beyond the stipulated period, or where a member engages in fraudulent conduct or any act prejudicial to the interests of the Scheme.

Benefits relating to pre-existing medical conditions may be subject to waiting periods as specified in the Scheme Rules. Members are encouraged to review these provisions before selecting their preferred plan.

Claims must be submitted within 3 months from the date of service. Claims received after this period may not be considered for payment unless exceptional circumstances are demonstrated.

All personal and medical information collected will be treated as confidential and used solely for the administration of the Scheme. The Fund implements appropriate technical and organisational measures to protect personal data against unauthorised access, loss, or disclosure.

Members have the right to receive information about their plan benefits, contribution rates, and any amendments to the Scheme Rules. FMH Botswana will communicate such updates through official written or electronic means.

Members may lodge complaints in writing to the Fund's Customer Service Department. If unresolved, the matter may be escalated to NBFIRA for mediation or adjudication.

The Fund shall not be liable for any failure or delay in the performance of its obligations under this Agreement due to circumstances beyond its reasonable control, including but not limited to acts of God, natural disasters, pandemics, or regulatory changes.

This Membership Application Form and Terms and Conditions are effective as of January 2026. The Fund reserves the right to update the Terms and Conditions periodically, subject to notification to members.

Please note that contributions are paid a month in advance. If contributions are not received for a period of ninety (90) days the membership will be terminated.

DECLARATION

I declare that the information contained in this form is materially true and complete in all respects. I acknowledge that this application shall constitute a binding agreement only upon written confirmation of acceptance by the Fund. I further agree to abide by the Rules, Benefits and Regulations of the Scheme as registered with the Non-Bank Financial Institutions Regulatory Authority (NBFIRA) and applicable laws of Botswana

I agree that should my application for membership be accepted, I will abide by the Rules, Benefits and Regulations set by First Mutual Health from time to time. I certify that none of my dependants suffer from any condition/s not declared. I authorise the deduction from my salary of the monthly contributions due in respect of my dependants and myself. Signing this application form, forms the basis of a contract between myself and First Mutual Health.

This contract shall be governed by and construed in accordance with the laws of Botswana, and any disputes shall fall under the exclusive jurisdiction of the courts of Botswana.

I acknowledge that should I terminate my membership before the medical benefit becomes payable there will be no refund of contributions.

By completing and submitting this Account Application Form, I/We, the undersigned, hereby consent to the processing of my/our personal data by First Mutual Health, including but not limited to the collection, storage, use, and sharing of such data for the purposes of fulfilling the requirements of this application, and complying with any applicable legal, regulatory, and contractual obligations. I/We also acknowledge that I/we have the right to withdraw this consent at any time, free of charge, by submitting a written request to First Mutual Health. Upon such withdrawal, First Mutual Health will cease processing my/our personal data, except where retention is necessary for legal or regulatory compliance. For the avoidance of doubt, the withdrawal of consent shall not affect the lawfulness of any processing carried out prior to such withdrawal.

The Fund will process your medical and other sensitive personal information in accordance with the Data Protection Act. Processing of such data will be limited to the purpose of administering benefits, underwriting, and regulatory compliance, and will be carried out under strict confidentiality and data security controls.

To view our full privacy notice and to exercise your preferences, please visit our website on https://www.firstmutualhealth.co.bw

Complaints regarding handling of personal data may be lodged with The Commissioner, Information and Data Protection Commission, Gaborone, Botswana whose contact details are: Finance House, Government Enclave, Private Bag 001 Gaborone. Phone +267 3950998 Email krakgati@gov.bw

Your personal information may be transferred or stored outside Botswana in compliance with the requirements of the Data Protection Act, subject to adequate data protection safeguards.

By signing this form, I consent to receiving marketing communications from First Mutual Health. I agree that First Mutual Health may send commercial electronic messages, including but not limited to SMS, WhatsApp, emails and newsletters, to my email address or various digital platforms that I may be on using my phone number provided herein. I understand that I have the right to opt-out of receiving marketing communications from First Mutual Health by following the unsubscribe instructions included in the message or by contacting First Mutual Health directly. I acknowledge that opting out of marketing communications may limit my access to certain promotions, offers, and other benefits provided by First Mutual Health.

We would like to contact you from time to time, regarding the products and services we offer across the Group as well as other pertinent information. This will enable us to serve you better and ensure that all your financial and investments needs are met. The security of your data is important to us, and we are committed to ensuring the protection of all personal information that we hold. Please tick the box below if you consent to hearing from us about the products and services we offer across the Group as well as other pertinent information;

I consent		I do not consent	

I consent to receive marketing communications from the Fund and companies within the FMHL Group, including but not limited to SMS, WhatsApp, email, and newsletters. I understand that I may withdraw my consent at any time without affecting my membership or access to benefit.

Signature of Principal Member_____ Date _____/_____/_____

A member of the FIRST MUTUAL HOLDINGS LIMITED