

THANK YOU FOR CONSIDERING OUR HEALTH COVER OPTIONS. PLEASE COMPLETE THIS FORM.

1. Personal Information

Full Name: _____

Employer Name: _____ Employee Role: _____

Email Address: _____ Phone Number: _____

Omang/Passport No. _____ Gender _____ Date of Birth _____

Residential Address: _____

2. Current Medical Cover Details

Do you have Medical Aid/ Insurance ☐ IF YES Please Complete (2.) ☐ IF NO Please Skip (2.)

Current Provider: _____ Policy Number: _____

Current Plan Name: _____ Policy Duration: _____

☐ I would like to **SWITCH COMPLETELY** from my current medical aid to Alpha Direct Health. ☐ I would like to **ADD** Alpha Direct Health as a **COMPLEMENTARY HEALTH** cover to my existing medical cover.

3. Your Preference

Please select **ONE** option below:

- ☐ Lite FROM P76) (*1 Entry-level hospital plan with P120,000 annual limit, core wellness screening and vaccines. Ideal for healthy individuals needing basic inpatient cover but **NO** day-to-day outpatient cover, chronic, dental or optical benefits.
- ☐ Essential FROM P281) (*1 Hospital cover up to P120,000 plus day-to-day benefits: outpatient limit of P40,000, chronic & prescription medicines, GP and specialist consultations, dental and optical, screening and wellness included.
- ☐ Core FROM P529) (*1 Mid-range cover with P300,000 hospital and P75,000 outpatient limits, dread disease included, stronger maternity, dental and optical, chronic & prescription medicine up to P30,000 and allied health for balanced family protection.
- ☐ Premier FROM P941) (*1 Comprehensive cover with P1.2M hospital and P150,000 outpatient limits, rich maternity, chronic and specialist care, dental and optical, infertility diagnostics and wellness benefits for worry-free cover.
- ☐ Status FROM P1,448) (*1 Flagship cover with P3M hospital and P 200,000 outpatient limits, extensive maternity, chronic cover within outpatient, enhanced dental, optical and allied health for executives wanting maximum protection.

¹Pricing is determined based on age, gender, and other relevant underwriting factors assessed during the onboarding process.

4. Policy Holder & Dependant Information (Required for quotation and coverage purposes)

Status	Full Name	Gender	Date of Birth	Do they have Medical Aid/ Insurance	
Dependant 1	_____	_____	(DD/MM/YYYY)	☐ YES	☐ IF NO
Dependant 2	_____	_____	(DD/MM/YYYY)	☐ YES	☐ IF NO
Dependant 3	_____	_____	(DD/MM/YYYY)	☐ YES	☐ IF NO
Dependant 4	_____	_____	(DD/MM/YYYY)	☐ YES	☐ IF NO
Dependant 5	_____	_____	(DD/MM/YYYY)	☐ YES	☐ IF NO

^{*2} Do you or any dependants have, or have previously been diagnosed with, a pre-existing medical condition? If Yes, Associated Fund Administrators Botswana (AFA), our delegated administrator, may contact you directly for additional medical information. **THESE ARE NOT SHARED WITH ALPHA DIRECT.**

☐ YES ☐ IF NO

²A pre-existing condition refers to any illness, disease, or medical condition that you or any of your dependants have been diagnosed with, treated for, or shown symptoms of within six (6) months prior to applying for cover. Examples include (but are not limited to; Hypertension, Diabetes, Asthma, Arthritis, Cancer, Depression, HIV/AIDS, Hepatitis, etc. (Full list available upon request).

Premium Quote (MONTHLY) _____

5. Data Processing

The privacy notice explains how we handle your personal and sensitive data during and after your relationship with us. Alpha Direct follows the Data Protection Act 2024 and relevant laws to ensure data security and integrity. We also adhere to GDPR principles to protect your data.

Personal Data Collection: "We collect personal data from you, such as your name, address, contact details and financial information, required to provide and administer your insurance policy."

Purpose of Data Collection: "We use your personal data for underwriting purposes, to assess your insurance needs, to set up and administer your insurance policy, handle claims, fraud prevention and detection. Similarly, we ensure that your data shall not be processed in a manner that is incompatible with the initial purpose"

Data Sharing: "We may share your personal data with relevant parties, including employees, insurers, brokers and fraud prevention agencies, to manage your insurance policy."

Cross-Border Data Transfers: "Alpha Direct Insurance Company ensures that any transfer of personal data outside Botswana, including to South Africa, is carried out only where adequate levels of data protection are guaranteed or under legally binding safeguards in accordance with Sections 24 and 62 of the Botswana Data Protection Act 2024. All such transfers are limited to the purposes stated in this notice and subject to appropriate technical and organizational measures to protect your information."

Automated Decisions: "We may use automated decision-making, including profiling, in our underwriting processes or claim handling. By proceeding, you consent to the use of your personal data."

Clinical Data Processing: "Alpha Direct Insurance Company does not process clinical or medical data unless specifically requested by the policy holder through an ex-gratia request. We engage Associated Fund Administrators (AFA) as our appointed fund administrator to access and process such medical or clinical information solely for purposes of medical assessment, claims validation, and healthcare administration related to your insurance policy. AFA acts as a data processor under our instruction and is bound by confidentiality and data-protection obligations consistent with the Botswana Data Protection Act, 2024. Should Alpha Direct appoint a different clinical administrator in the future, you will be notified, and your consent will be obtained again, or processing will proceed only under another lawful basis permitted by the Act."

Data Storage: "We store personal data securely in a form which permits your identification. The processing personal data of your data shall be stored in Botswana and retained for a period as prescribed by Botswana legislations and will be securely disposed of thereafter."

Data Protection Rights: "You have the right to request access to, correction of, or deletion of your personal data, to limit or object to our processing of your data, and to request data portability."

Data Processing Outside of Jurisdiction: "Alpha direct has an online backup system in South Africa. Therefore, we may process your data outside of your jurisdiction. By proceeding, you consent to this cross-border transfer of your personal data."

6. Data Privacy Consent To express your consent, kindly show by placing a tick on the relevant boxes as provided below:

☐ YES ☐ NO **Consent (COMPULSORY):** "By proceeding with this policy, you consent to our collection, use, storage, and sharing of your personal data as described above."

☐ YES ☐ NO **Processing of data for marketing purposes (OPTIONAL):** "Alpha Direct may process your data for purposes of direct marketing."

Withdrawal of Consent: "You have the right to withdraw your consent at any time. Please note that withdrawal of consent may result in certain consequences, such as inability to maintain your insurance policy."

To withdraw consent, please contact the following:

The Data Protection Officer
Alpha Direct Insurance Company
P O Box 26ADC, Gaborone
Email: dpo@alphadirect.co.bw

7. Payroll Authorization

I, **THE UNDERSIGNED EMPLOYEE**, acknowledge that I have applied for health insurance cover with Alpha Direct Insurance Company, operating through Alpha Direct Health ("the Insurer"), under the product option selected in this application, including cover for any eligible dependants listed herein. I hereby authorize and instruct my Employer and its Payroll Department to deduct from my salary or wages the premium amounts due and payable for this policy and to remit such amounts to the Insurer on my behalf.

I UNDERSTAND AND ACCEPT that the premium deducted from my salary is determined by the product selected, the number and category of dependants covered, my age and the ages of my dependants, underwriting outcomes where applicable, and any other premium rating factors in accordance with the Insurer's policy rules. I further acknowledge and agree that the premium amount, and therefore the payroll deduction, may vary over time as a result of policy dynamics, including but not limited to the addition or removal of dependants, changes in dependant eligibility, movement into different age-based premium bands, annual premium reviews or inflationary adjustments, benefit upgrades or downgrades, or any other change permitted or required under the policy terms or applicable law. I authorize my Employer to implement any revised deduction amount as communicated by the Insurer, without requiring a new signed mandate, provided such deductions relate to this policy.

I ACKNOWLEDGE that payroll deductions will commence from the policy commencement date or the first available payroll cycle, thereafter, as confirmed by the Insurer, and will continue for as long as this policy remains in force and premiums remain payable. I understand that where payroll

deductions cannot be made in full due to insufficient salary, unpaid leave, payroll interruption, or any other reason, premiums may remain outstanding and my cover may be suspended or cancelled in accordance with the policy terms. I accept that I remain responsible for all premiums due under this policy, whether or not my Employer is able to deduct them from my salary.

I ACKNOWLEDGE that my Employer's role is limited to processing payroll deductions and remitting premiums to the Insurer, and that my Employer is not responsible for policy administration, benefit decisions, underwriting determinations, or claims outcomes, all of which remain the responsibility of the Insurer. I understand that I may revoke this payroll authorization by providing written notice to the Insurer and/or my Employer, subject to the Insurer's policy cancellation rules, and I further acknowledge that cancelling payroll deductions does not automatically cancel the policy unless I also comply with the Insurer's formal cancellation process. Should I dispute any deduction, I will notify the Insurer promptly, and I understand that any confirmed over-deduction will be refunded or credited in line with the Insurer's refund policy and payroll processing timelines.

I DECLARE that I have read and understood the relevant Policy Wording, Key Facts, and Benefit Schedule (where applicable), that the information provided in this application is true, complete, and accurate to the best of my knowledge, and that I accept responsibility for ensuring that premiums are paid via the payroll deductions authorized herein.

SIGNATURE _____

DATE _____

8. Consent & Declaration

I AND ANY DEPENDANTS applying for cover under this application hereby authorize any physician, healthcare professional, hospital, clinic, pharmacy, laboratory, or other healthcare institution ("Providers") to disclose, to the extent permitted by applicable law, to Alpha Direct Health's appointed Third-Party Administrator ("TPA"), and when necessary, to Alpha Direct Insurance Company acting through its health division ("Alpha Direct Health" or "the Insurer"), any information relating to the medical history, condition, diagnosis, treatment, services, supplies, or healthcare received by any person listed in this application, including information relating to dental conditions, substance use disorders, HIV and/or AIDS, and any other relevant healthcare information.

I ACKNOWLEDGE AND UNDERSTAND that submission of this application, and/or the payment or deduction of any premium, does not guarantee acceptance or cover. I further acknowledge that Alpha Direct Health reserves the right, in its sole discretion and in accordance with its underwriting rules and applicable law, to decline to underwrite or insure any applicant or dependant, to impose waiting periods, exclusions, loadings, or other terms, and that cover will only commence once the application has been formally accepted and confirmed in writing by the Insurer.

I ACKNOWLEDGE AND AGREE that the TPA is responsible for collecting, holding, managing, and processing clinical and healthcare information for the purposes of medical assessment, claims validation, and healthcare administration related to this policy. I further acknowledge that Alpha Direct Insurance Company does not process clinical or medical data unless specifically requested by the policy holder through an ex-gratia request. In such circumstances, any clinical or medical information shared with Alpha Direct Health will be limited to what is lawful, necessary, and relevant to the ex-gratia assessment. The TPA acts as a data processor under Alpha Direct Health's instruction and is bound by confidentiality and data-protection obligations consistent with the Botswana Data Protection Act, 2024. Should Alpha Direct Health appoint a different TPA or clinical administrator in the future, I understand that I will be notified, and my consent will be obtained again, or processing will proceed only under another lawful basis permitted by the Act.

I UNDERSTAND that I may decline to provide consent for the processing of personal or healthcare information; however, I acknowledge that doing so may result in a decline of cover, inability to administer benefits, or cancellation of the policy in accordance with policy terms.

I UNDERSTAND that I have the right, to the extent allowed by law, to request access to my personal or healthcare information held by the TPA, to request correction of inaccuracies, and to obtain a copy of this authorization upon request. I acknowledge that a copy or electronic version of this authorization is as valid as the original. I may revoke this authorization at any time by providing

written notice to Alpha Direct Health and/or the TPA, provided that such revocation will not apply to actions already taken in reliance on this authorization before the date of revocation and may affect the continuation of my cover.

THIS AUTHORIZATION SHALL REMAIN VALID for the duration of the policy and for such additional period as permitted by applicable law, including time reasonably required to administer claims, resolve disputes, conduct audits, or meet legal and regulatory obligations.

I UNDERSTAND that it is unlawful for me or any of my dependants to knowingly provide false, incomplete, or misleading information to Alpha Direct Health or the TPA for the purpose of obtaining cover, benefits, or reimbursement. I acknowledge that such conduct may result in denial of claims, rescission of benefits, cancellation of cover, recovery of amounts paid, and any other remedies available under the policy, common law, or statute.

I ACKNOWLEDGE that Providers who participate in Alpha Direct Health's provider network act as independent practitioners or institutions and are not employees or agents of Alpha Direct Health or the TPA, and that neither Alpha Direct Health nor the TPA is responsible for clinical decisions made by Providers.

I CONFIRM that I have read and understood the documents provided to me in relation to this application, including the Key Facts, Policy Wording, Benefit Schedule, and any applicable TPA rules or clinical protocols, and that I agree to the terms and conditions of the policy. I further acknowledge that I may cancel this policy within any applicable cooling-off period as stated in the policy documentation, and that thereafter cancellation will be subject to the policy rules.

I UNDERSTAND AND ACCEPT that where treatment is obtained by myself or any of my dependants within the Provider Network, and it is later established that such treatment or condition is not covered or is non-refundable in terms of the policy, I, as the policyholder, remain liable to reimburse Alpha Direct Health for amounts paid on my behalf within the timeframe stated in the policy. I acknowledge that failure to repay outstanding amounts may result in suspension or cancellation of cover, and that no claims for treatment received during a period of suspension will be paid.

I DECLARE that the answers given in this application are, to the best of my knowledge, full, true, and complete, including those not written in my own handwriting, that I have disclosed all material facts relevant to this application, and that I am satisfied that the product selected meets my needs at the time of application.

**APPLICANT
NAME**

SIGNATURE

DATE

6. Human Resources Authorization *(Completed by Human Resources Liaison)*

**AUTHORIZED
NAME**

SIGNATURE

DATE

COMPANY STAMP