TERM LIFE CLAIM FORM

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life (Fiji) Limited, GFL BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

A. TYPE OF CLAIM

Please tick (√) the appropriate claim type below and complete the sections relevant to that claim.

☐ Death ☐ Total and Permanent Disability (TPD) ☐ Personal Accident (PA) - Scale ☐ Critical Illness (CI)

For any **Total and Permanent Disability (TPD), Personal Accident (PA), Critical Illness (CI)** claim, please get your doctor/medical provider to complete the ***Medical Provider's Statement*** on **page 5** and post it directly to BSP Life.

B. DETAILS OF LIFE INSURED

	Given Name(s)	Surname
Mr/Mrs/Miss/Ms		

Date of Birth / / Policy Number

Home Address

Is the Life Insured the policy owner?

☐ Yes ▶ Go to **Section D**

☐ No ▶ Complete **Section C** and **Section D**

C. DETAILS OF POLICY OWNER (Employer, Group, Organisation, or Other)

Name

Telephone Facsimile Email

Postal Address

D. DETAILS OF BENEFICIARY/CLAIMANT

	Given Name(s)	Surname
Mr/Mrs/Miss/Ms		

Relationship to Life Insured

Certified copy of birth or marriage certificate (if applicable) attached ☐ No ☐ Yes

Postal Address

Telephone Email

E. DEATH CLAIM

Date of Death / / Place of Death

Medical Attendant by whom Death Certified

Cause of Death

1. List all physicians/doctors or other medical practitioners consulted for any condition related to the cause of death in the past five (5) years.

Name	Address	Dates Consulted

2. List all hospital confinements in the past five (5) years.

Name	Address	From	To	Reason for Confinement

Supplementary Requirements [Please tick (√) the requirements you have attached to this form]

Certified copy of Death Certificate Certified copy of Birth Certificate Medical Reports Police Report (if required)

F. TOTAL AND PERMANENT DISABILITY CLAIM

For any **Total and Permanent Disability** claim, please get your doctor/medical provider to complete the ***Medical Provider's Statement*** on **page 5** and post it directly to BSP Life.

1. State the nature of the illness or injury which caused you to cease your work/current duties.

2. When did you first experience difficulty arising out of the above illness or injury?

3. Have you previously had this illness or injury? No Yes ▶ Please give dates and provide details below.

Date	Details

4. When do you expect to return to your work/current duties?

5. Are you entitled to any other disability benefits or Worker's Compensation?

   No Yes ▶ Please give details and name of insurer below.

   Name of Insurer

   Telephone Facsimile

   Postal Address

6. State names and addresses of doctors/physicians attending to you who would be able to provide information regarding your condition and treatment.

Name	Address	When Treated	Nature of Treatment

7. Are you required to regularly attend any surgery, hospital or clinic for treatment?

   No Yes ▶ Please give details below.

Name and address of place attended	How Often	Treatment (e.g. X-Ray, Dialysis, Injection etc)

8. Please describe your work/current duties in detail and whether or not you use special equipment or tools (please list).

Details of Current Work/Duties	Tools/Equipment Used

9. Does your work/current duty involve any physical requirements (e.g. lifting or carrying load)?

   No Yes ▶ Please give details below.

10. Have you been able to perform any of your work/current duties since your disability began?

    None Part-time Full Time

G. PERSONAL ACCIDENT CLAIM

For any **Personal Accident** claim, please get your doctor/medical provider to complete the ***Medical Provider's Statement*** on **page 5** and post it directly to BSP Life.

1. State the nature of the injury caused by the accident.

2. When and how did the accident happen? (Please attach on separate sheet if insufficient space)

3. When did you first consult a doctor? ▶ Please give doctor's name and contact details below.

   Name of Doctor

   Telephone Facsimile

   Postal Address

4. Name your employer at the time of the accident and your weekly earnings.

Employer Name	Position/Title	Weekly Earnings
		$ p.w.

5. Are you entitled to any other compensation for this accident from any other company or under the Accident Compensation Act?

   ☐ No ☐ Yes ▶ Please give details and name of the company.

   Company Name

   Telephone Facsimile

   Postal Address

6. Have you had any previous accidents requiring medical attention?

   ☐ No ☐ Yes ▶ Please give doctor's name and contact details.

   Name of Doctor

   Telephone Facsimile

   Postal Address

7. What work/current duties are you unable to perform? Please give details.

   1.
   2.
   3.
   4.

8. How long have you been **completely incapacitated** and unable to perform **every** work/current duty due to this accident? weeks

9. How long have you been **partially** disabled and unable to perform **one** or **more** work/current duties due to this accident? weeks

10. If you are still disabled please state when you expect to return to partial or full work/current duties. From / /

H. CRITICAL ILLNESS CLAIM

For any **Critical Illness (CI)** claim, please get your doctor/medical provider to complete the ***Medical Provider's Statement*** on **page 5** and post it directly to BSP Life.

1. State the nature and details of the illness.

2. When did you first consult a doctor regarding this illness?

Please give doctor's name and contact details below.

Name Telephone

Postal Address

3. Have you suffered from the same or similar illness previously? No Yes ▶ Please give details below.

Date	Details of any disability associated with illness

4. Have you been advised to have any surgical operation in connection with the present illness?

No Yes ▶ Please give details below.

5. Name of your employer, your position and your weekly earnings at the time of the illness.

Employer Name	Position/Tile	Weekly earnings
		$ p.w.

6. Has this illness either **completely incapacitated** you from performing **every** work/current duty or confined you to your house or a hospital?

No Yes ▶ Please give details of the duration you have been disabled or confined.

From: To:

7. When did you, or on what date do you expect to return to work/current duties?

Part Time Full Time From: / /

I. BENEFIT PAYMENT DETAILS (Benefit Payment will only be made if premium payments are in order)

Note: Cheques will only be made payable to the Policy Owner or Beneficiary in case of a Death claim where the Policy Owner is also the Life Insured.

Please pay me by cheque ▶ To be collected by me Posted to me at the above postal address

Please arrange to have someone see me in regards to investing part or all of my benefit payment into a BSP Term Deposit account.

J. DECLARATION AND AUTHORISATION (To be completed by the Beneficiary/Claimant/Policy Owner)

I declare that the information provided in this form is true, complete and correct.

I understand that BSP Health Care (Fiji) Limited ("BSP Life") will use the information provided in this form for purpose of evaluating a claim for insurance benefits.

I authorise any medical professional, hospital or other medical-care institution, medical laboratory, insurance support organisation, pharmacy, government agency, insurance company, employer or benefit plan administrator, to provide to BSP Life any information concerning my employment, or insurance or any medical information.

I agree that a photocopy of this authority will be as valid as an original.

Signature of Beneficiary/Claimant/Policy **Date**

Witness **Date**

MEDICAL PROVIDER'S STATEMENT

(To be completed for Hospitalisation/Cash Allowance & Prior Approval Claim and on request by BSP Health Care)

Please ask your Doctor/Service Provider to complete this statement.
BSP Life is **NOT** liable for any changes levied by your Physician for this statement.

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. What is your patient claiming for?
   ☐ Total and Permanent Disability (TPD) ☐ Personal Accident (PA) - Scale ☐ Critical Illness (CI)
2. Patient's Name _____ Patient's Date of Birth / /
3. Diagnosis or nature of injury of illness (please indicate primary and secondary)
4. Date of injury or first symptoms of illness _____
5. How long have you known the patient? _____
6. Date patient consulted you for this injury or illness First Consultation _____
   Last Consultation _____
7. List all the dates on which the patient has consulted you for this injury or illness.

Date	Treatment Received	Date	Treatment Received

8. Are you still treating the patient for this injury or illness? ☐ No ☐ Yes
9. Was this injury or illness an emergency? ☐ No ☐ Yes
10. Objective findings (give details of any X-Ray, ECGs or Other Tests)

Date	Test	Results

11. Nature of treatment (including any complications)
12. Has the patient consulted you for any other condition in the past five (5) years?
    ☐ No ☐ Yes ▶ Please give details below.

Reason for Consultation	Date Consulted	Treatment/Advice Received

13. Is this current injury or illness a recurrence? No Yes

14. Has patient had a similar injury or illness? Please give dates and details.

Date	Nature of injury or illness?	Treatment	Results

15. Are there any other conditions or circumstances affecting recovery from the current injury or illness?

No Yes ▶ If Yes, please advise nature of conditions or circumstances & how they affect recovery.

16. Date of Total Disability

From: To:

17. Date of Partial Disability

From: To:

18. Please indicate the level of incapacity assessed in percentage (%)

19. Please list what work/current duties the patient is unable to perform

1.	4.
2.	5.
3.	6.

20. Do you expect any significant improvement in the patient's condition in the future? No Yes

If Yes, please specify on what date the patient can return to work

21. Hospitalisation Dates From: To:

22. Additional Remarks

23. Medical Provider's Name

Telephone Facsimile Email

Postal Address

Medical Provider's Signature

Date: Registration No.: Stamp:

INSTRUCTIONS TO MEDICAL PROVIDER

Please send the "Medical Provider's Statement" in an envelope marked "CONFIDENTIAL" and address to:

The Claims Manager
BSP Health Care
Private Mail Bag, Suva, Fiji.

Call Centre: 132 700 | 24-hour Health Care Help Desk (679) 321 4444 | Fax: (679) 3308340