MEDICAL INSURANCE APPLICATION

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health Care (Fiji) Limited, Ground Floor, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: (679) 331 7000 Call Centre: 132 700 Facsimile: (679) 330 8955 Web: www.bsplife.com.fj

Proposal Number

PLEASE READ THESE NOTES:

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- The Primary Applicant must initial all changes made on this application and ensure all details are true and correct.
- The Medical Insurance Application Guide should be used to complete this form.
- The form must be submitted with the relevant supporting documentation listed in the Medical Insurance Application Guide and the Medical Insurance Supplementary form (if applicable).

What you must tell us

- When answering our questions you have a duty under the law to tell us anything known to you, and which a reasonable person in the circumstances, would include in answer to the questions.
- We will use the answers to determine whether to insure you and anyone else under the policy, and on what terms.

Who needs to tell us

- It is important that you understand you are answering our questions for yourself and anyone else whom you want to be covered by the policy.

If you do not tell us

- If you fail to answer our questions correctly, we may reduce or refuse to pay a claim, or cancel the policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the policy as void.
- When in doubt, please disclose. We treat all information confidentially.

SECTION A. PRIMARY APPLICANT DETAILS

For Office Use Only
- Client ID (for existing client)

1. Personal Details

Title | First Name | Middle Name

Last Name | Date of Birth (DD/MM/YYYY) | Ethnicity

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ De-Facto

Residential Status in Fiji: ☐ Resident ☐ Non-Resident

2. Identification Details *Complete any of the following identification details below for verification purposes.*

Identification Type	Identification Number	Expiry Date	Identification Type	Identification Number	Expiry Date
FNPF Card			Passport *(include country)*		
FNPF & FRCA Joint Card			Voter Registration Card		
Driver's License			Student Identification Card		
TIN Letter			Other		

State a Secret Question:

Answer to Secret Question:

3. Contact Details

Residential Address:

Postal Address: Same as Residential Address ☐ Yes ☐ No ▶ *If no, please provide postal address details:*

Work No: | Home No: | Mobile No: | Facsimile No:

Email Address: | Alternate Email Address:

Preferred Contact Phone to Use: | Preferred Time to Contact: | Consent to Electronic Communication: ☐ Yes ☐ No

4. Bank Details

For efficient payment processing, BSP Health makes payments by Electronic Funds Transfer directly into the bank account nominated by you. Please ensure that the nominated bank account details are correct. BSP Health will not be held responsible for payments made to a third party account if payment is authorised by you and you indemnify BSP Health to the fullest extent possible from any liability whatsoever arising from the payment of funds into the nominated account.

Bank Name | Bank Account Number | Bank Account Name

SECTION B. OCCUPATION DETAILS *(To be completed by the Primary Applicant)*

1. What industry are you employed in?

2. Date Appointed to Position (DD/MM/YYYY)

3. What is your current main occupation?

4. Describe your major duties (including details as applicable of heights, depths and location at which you work, and chemicals, gases or any toxic substances used) and provide percentage (%) of time on each major duty.

Major Duties	Percentage (%) time on each duty

SECTION C. SPOUSE AND DEPENDENT(S)

(If a Dependent is over 18 years old, please provide proof of full time student status)

First Name	Middle Name	Last Name	Date of Birth	Gender	Relationship to Primary Applicant	Residential Status in Fiji

For sections D-F: A Medical Insurance Supplementary Form must be completed and included for each Life to be Insured (Spouse or listed Dependent(s)) whose details differ from the Primary Applicant. Only complete the section where there is a difference.

SECTION D. COVER DETAILS

(Please tick the level of cover you, your Spouse and Dependent(s) are applying for)

Individual Policy	Riders					
Base Product	Dental and Optical Care	Allied Health Care	Premier Outpatient	Outpatient Care Plus	Outpatient Care	Medivac Care
☐ Premier Plus	☐	☐	☐	☐	☐	N/A
☐ Premier Care	☐	☐	☐	☐	☐	N/A
☐ Value Care SP	☐	☐	☐	☐	☐	☐
☐ Value Care	☐	☐	☐	☐	☐	☐
☐ Other						

Group Policy	Riders						
Base Product	Dental and Optical Care	Allied Health Care	Premier Outpatient	Outpatient Care Plus	Outpatient Care	Group Medivac Care	Group Medivac Plus
☐ Group Premier Plus	☐	☐	☐	☐	☐	N/A	N/A
☐ Group Premier Care	☐	☐	☐	☐	☐	N/A	N/A
☐ Group Value Care SP	☐	☐	☐	☐	☐	☐	☐
☐ Group Value Care	☐	☐	☐	☐	☐	☐	☐
☐ Other							

Nominated Provider *(Nominate a Provider from the BSP Health Preferred Provider List. Applicable to Outpatient Care and Outpatient Care Plus riders)*

Name of Nominated General Practitioner

Name of Nominated Pharmacy

SECTION E. MEDICAL DETAILS

(To be completed by the Primary Applicant)

1. Height and Weight?

Name of Life to be Insured	Height (cm)	Weight (kg)	If your weight has changed by more than 20kgs in the last 12 months please indicate below.	▸ *Please state reason for change:*
			☐ Increase ☐ Decrease	
			☐ Increase ☐ Decrease	
			☐ Increase ☐ Decrease	
			☐ Increase ☐ Decrease	

			☐ Increase ☐ Decrease	
			☐ Increase ☐ Decrease	

2. Name of usual Medical Attendant, General Practitioner (GP) or Clinic?

Name of Life to be Insured	Name of GP or Clinic	Telephone Contact	Postal Address	How long have you, your Spouse or listed Dependent(s) been visiting this GP or Clinic?

3. What other medical providers have you, your Spouse or any listed Dependent(s) used in the past?

4. Have you, your Spouse or any listed Dependent(s) migrated to Fiji within the last 5 years? ☐ No ☐ Yes ▸ *If yes, please provide the following details in reference to your previous country of residence:*

Name of usual GP or Clinic	Telephone Contact	Postal Address

5. Medical Insurance History

(a) Have you, your Spouse or any listed Dependent(s) ever had any other medical insurance prior to applying to BSP Health? ▸ *If yes, please provide the following details:*

Name of Previous Insurer	Insurance Expiry Date	Type of Cover	Reason for Change

(b) Do you, your Spouse or any listed Dependent(s) have policies with any other medical insurance scheme? ☐ No ☐ Yes ▸ *If yes, please provide details:*

(c) Have you, your Spouse or any listed Dependent(s) made a medical insurance claim in the past? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Name of Insurer	Reason for Claim	Claim accepted and Paid
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

(d) Have you, your Spouse or any listed Dependent(s) had any medical, disability or life insurance application declined, deferred or accepted on special terms? ☐ No ☐ Yes ▸ *If yes, please provide details:*

SECTION F. HEALTH DECLARATION

You must disclose details of any Existing Medical Conditions or symptom occurring before the commencement of your policy. When in doubt, please disclose or contact our Customer Call Centre on 132 700 for clarification.

An Existing Medical Condition means any chronic or ongoing (whether arising from a chronic condition or otherwise) medical condition, injury, illness or disease of which the Insured is aware or should reasonably have been aware, and which is medically documented or under investigation prior to commencement of your policy (if your application is accepted and a Policy Certificate issued), or any physical or mental illness or medical condition (including pregnancy related) defect, injury, illness or disease of which the Insured is aware or should reasonably have been aware of for which treatment, medication, preventative medication, advice, preventative advice or investigation has been received prior to commencement date where any symptom is the subject of an investigation, that symptom or condition falls within this definition, regardless of whether or not a diagnosis has been made.

Have you, your Spouse or any listed Dependent(s) ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms for any of the following conditions or any Existing Medical Condition? ▸ *If you answer yes to any of the questions below, please complete the relevant Supplementary Personal Statement Form(s).*

1.	Abnormal blood pressure, angina, chest pain or discomfort, abnormal electrocardiogram (ECG), rheumatic fever/ heart diseases, coronary heart disease, heart attack, heart murmur or any cardiovascular diseases.	☐ No ☐ Yes
2.	Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders.	☐ No ☐ Yes

3.	Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, paralysis, fainting episodes, depression or any type of mental disorders, or epilepsy.	☐ No ☐ Yes
4.	Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the respiratory system, or pleurisy or emphysema.	☐ No ☐ Yes
5.	Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of gastrointestinal tract disorders, or the passing of blood.	☐ No ☐ Yes
6.	Kidney, bladder or prostate diseases, including renal colic or stone, urinary tract infection and passing of blood in the urine.	☐ No ☐ Yes
7.	Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular - skeletal disorders, disc lesion, or other back trouble including lumbago, fibrositis, sciatica or whiplash injury.	☐ No ☐ Yes
8.	Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat.	☐ No ☐ Yes
9.	Diabetes or pancreatic diseases, abnormal blood sugar level, thyroid or any hormonal disorders.	☐ No ☐ Yes
10.	Cancer, tumour, cyst or growth of any type whether it be benign or malignant.	☐ No ☐ Yes
11.	Skin disorder(s) of any type for example, skin lesion and melanoma.	☐ No ☐ Yes
12.	Sexually transmitted infections including syphilis, gonorrhoea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies.	☐ No ☐ Yes
13.	Night sweats, inexplicable weight loss, persistent fever, diarrhoea or swollen glands.	☐ No ☐ Yes
14.	**Males Only** - Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder, urethra.	☐ No ☐ Yes
15.	**Females Only** - Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems.	☐ No ☐ Yes
16.	Any other illnesses, injury, operation, disability or physical abnormality.	☐ No ☐ Yes

17. Have you, your Spouse or any listed Dependent(s) ever been refused as a blood donor, or had any blood test or other testing services or ever received a blood transfusion; treatment with human blood products or an organ transplant? ☐ No ☐ Yes ▸ *If yes, please provide details:*

18. During the past 5 years have you, your Spouse or any listed Dependent(s) had any medical examination, advice, treatment, surgical operation, x-ray, ECG, computerised tomography (CT) scan, magnetic resonance imaging (MRI) or any other test or investigation not disclosed in the Health Declaration Questions? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Date	Name of GP or Clinic	GP or Clinic Address	Reasons for Treatment or Test	Test Results

19. Have any of your parents, brothers or sisters died or suffered from heart disease including cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, polycystic kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy, or Spouse suffered or died from tuberculosis, hepatitis, AIDS or AIDS related conditions? ☐ No ☐ Yes ▸ *If yes, please provide the following details of your family history:*

Family Member Name	Relationship to life to be Insured	Medical Condition	Age at Diagnosis or Death

20. Have you, your Spouse or any listed Dependent(s) in the last 2 years smoked or ever smoked tobacco or used any other narcotic substance, consumed kava, alcohol or any other drugs or intoxicants? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Substance		Type	Daily Quantity
Smoke	☐ No ☐ Yes		
Kava	☐ No ☐ Yes	N/A	*litres/day*
Alcohol	☐ No ☐ Yes		
Other Drugs or Intoxicants	☐ No ☐ Yes		

SECTION G. BENEFICIARY

(For individual policies, the nominated beneficiary must be 18 years of age and more. For group policies, the benefit will be paid to the group)

1. Individual Details *(if Beneficiary is an Individual)*

Title	First Name	Middle Name	Last Name	Date of Birth	Gender	Relationship to the Primary Applicant

2. Entity Details *(if Beneficiary is an Entity)*

Entity Name	Percentage Distribution

Contact Person Name and Position

Registered Address

SECTION H. PREMIUM PAYMENT DETAILS

Please tick your preferred payment option. Premiums are payable in advance. If paying by salary deduction please complete a Salary Deduction Authority Form. If paying by bank deduction, please complete a Bank Deduction Authority Form. Please note payments other than on an annual basis will attract a Payment Frequency Loading.

Salary Deduction: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Semi-Monthly 1st & 15th

Group Paying: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Semi-Monthly 1st & 15th ☐ Quarterly ☐ Six-Monthly ☐ Annually

EDP Pay Number

Name of Group Scheme *(if applicable)*

Direct Payment: ☐ Quarterly ☐ Six-Monthly ☐ Annually

For direct payment, please select the payment method ☐ Bank Deduction ☐ BSP Life Cashier

Premium Paid

$

Receipt Number

Other Payment Channel *(attach deposit/internet banking slip)*

SECTION I. PROPOSED POLICY COMMENCEMENT DATE

DD/MM/YYYY

Please advise whether you require the Policy to commence on a specific date. It must be a future date, however, it cannot be a date more than 90 days from the date of this application. BSP Health will try to accommodate your request but this is not guaranteed and will be subject to BSP Health's decision on acceptance.

SECTION J. THIRD PARTY DETAILS

I hereby authorise the third party to deal with BSP Health on my behalf.

Title

First Name

Middle Name

Last Name

SECTION K. DECLARATION AND CONSENT

INSURANCE ADVISOR/THIRD PARTY DECLARATION *(Please select where appropriate)*

This declaration must be completed if this application form has been filled in by a BSP Health Insurance Advisor or a third party other than the Life to be Insured/Policy Owner.

1. I _____ of _____ occupation _____ certify that the Life to be Insured/Policy Owner was unable to fill in this application on the Life to be Insured/Policy Owner's behalf.
2. I certify that the information given to me by the Life to be Insured/Policy Owner has been accurately and honestly recorded by me in this application form.
3. I certify that the information filled out in this application form has been read back to the Life to be Insured/Policy Owner and explained to him/her in the English/Fijian/Hindi/Chinese/other language and the Life to be Insured/Policy Owner understands its content thereof.

Full Name of BSP Health Insurance Advisor/Third Party

Signature

Signed at

Date

Full Name of Witness

Signature

Signed at

Date

GENERAL DECLARATION *(To be completed by the Primary Applicant)*

1. **I declare** that to the best of my knowledge, the information provided in this application and accompanying this application is true, correct and complete and I will notify BSP Health of any changes.
2. **I declare** that all nominated Dependent(s) aged from 18-24 covered by this application are undertaking full time study in an accredited educational institution. I acknowledge that I will need to provide proof of this at each renewal.
3. **I understand** that premium rates and benefit entitlements incorporated in the terms and conditions of the Policy may change from time to time.
4. **I understand** that the information BSP Health collects in this application form and in the wider application process will be used to consider and process this application and if approved, consider the specific terms to apply to the Policy.
5. **I understand** that I have a duty to disclose to BSP Health anything known to me which a reasonable person in the circumstances, would disclose in this application.
6. **I understand** that failure to disclose information or the failure to provide full and correct information to BSP Health may make the contract void and if such non-disclosure is fraudulent, BSP Health may take legal action against me.
7. **I understand** that if my application is approved, cover is not provided for Existing Medical Conditions under the Policy and certain waiting periods will apply before I can claim benefits under the Policy.
8. **I authorise** BSP Health to disclose information about my application to my Insurance Advisor or Broker.
9. **I consent** to BSP Health or its contracted service providers recording any telephone calls between myself and BSP Health and/or the service providers.

10. **I agree** that a scanned copy or photocopy of this authority will be as valid as an original.
11. **I authorise** BSP Health to collect from and to disclose to:
    - my Spouse or any Dependent(s);
    - any person nominated by me in writing;
    - third parties such as my employer, health service providers, medical authorities, agents, contractors, suppliers and other business partners all relevant personal and medical information relating to the people named in this form, and **I authorise** these parties to disclose to BSP Health and receive from BSP Health all information required to confirm benefit entitlements under the Policy for myself and the Dependent(s) listed on this application.
12. **I authorise** BSP Health to obtain personal and medical information from the persons listed above (11) and use this information to the extent necessary for the assessment of this application and any claim made under the Policy.
13. **I authorise** BSP Health to provide a copy of this signed consent and a declaration as confirmation to external providers when requesting information for the assessment of this application and any claim made under the Policy.
14. In relation to the named Spouse and listed Dependent(s) in this application, **I confirm** that:
    - I am authorised to complete this application form on their behalf;
    - I am authorised to disclose to BSP Health and receive from BSP Health their personal and health information;
    - I am duly authorised to provide the information, acknowledgements, undertaking and authority set out in this form on their behalf.
15. **I understand** that BSP Health may communicate with me via electronic means such as email, fax, or via an SMS message or phone call. If I have consented to electronic communication, **I understand** that by providing the authorisation in this form and signing in the space provided, **I consent** to communicate electronically with BSP Health about my policies and authorise BSP Health to act on instructions it receives electronically. This consent and authority applies to all communications permitted to take place electronically by law including but not limited to statements of account, notices and other communications to me about my policy, variations to the contract relating to my policy and relevant notices. By giving this consent, **I understand** that BSP Health is no longer required to send me notices or other documents for my policy in paper form.
16. **I understand** that if I have consented to electronic communication, I am responsible for ensuring that I maintain the appropriate software and hardware to access, view, retrieve, print and save a copy of any documents sent to me via electronic means. **I will ensure** that I will check my email regularly for notices and other communications from BSP Health. **I will ensure** that where provided, my email address remains current and emails sent from BSP Health to my account are not blocked.
17. **Please tick ONE of the boxes below:**

    ☐ **I agree** that my contact information contained on this Application be disclosed to other entities within, managed or contracted by BSP Health for the purpose of marketing products to me that are offered from time to time or for the purpose of customer surveys and authorise those entities to seek access to that information. **I understand** that my personal information and confidential information about my health will not be disclosed to third parties, only my contact information.

    ☐ **I do not agree** that information contained on this Application be disclosed to other entities within, managed or contracted by BSP Health.
18. **Please tick ONE of the boxes below:**

    ☐ **I agree** that BSP Health is able to send me information from entities of the BSP Group, including BSP Bank and BSP Finance for the purpose of marketing products to me that are offered from time to time.

    ☐ **I do not agree** that BSP Health is able to send me information from entities of the BSP Group for the purpose of marketing products to me that are offered from time to time.

Full Name of Primary Applicant

Signature/Thumb Print	Signed at	Date

Full Name of Witness

Signature	Signed at	Date

Full Name of Insurance Advisor/Broker	Insurance Advisor/Broker Number	Sales Unit/Broker

Signature	Signed at	Date

FOR OFFICE USE ONLY

Checklist:

- ☐ Date and received stamp the form
- ☐ Form is fully and correctly completed
- ☐ Required premiums have been receipted
- ☐ Supporting documentation is attached to form
- ☐ Change Salesperson application has been processed (if applicable) before the policy reinstatement application is created on BLIS.

Comments

Received By Department/Sales Unit:

Received/Checked By	Name	Signature	Date

Authorised By	Name	Signature	Date