TERM LIFE 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: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

Proposal Number

What you must tell us

When answering our questions you have a duty under 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 to be insured 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.

PLEASE COMPLETE ALL DETAILS IN CAPITAL LETTERS AND TICK THE APPROPRIATE BOXES

The Proposed Policy Owner and the Life to be Insured must initial all changes made on this application and ensure all details are true and correct.

A. PROPOSED POLICY OWNER DETAILS

Policy Owner Type ☐ **Individual** ▸ *If an Individual is selected, please complete the following details in Section A1 below*
☐ **Legal Entity** ▸ *If a Legal Entity selected, please complete the following details in Section A2 below*

1. Title | First Name | Middle Name | Last Name

Date of Birth (DD/MM/YYYY) | Gender ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ De-facto | Residential Status in Fiji ☐ Resident ☐ Non-resident

Complete only one of the following identification numbers below:

TIN Number | FNPF Number | Driver's Licence Number | FRCA/FNPF Joint ID Card Number

Your secret question

Your answer to secret question

EDP/Pay Number | Bank Name | Bank Account Number | Bank Account Name

Consent to communicate electronically ☐ Yes ☐ No | Email Address

2. Name of **Legal Entity** (In Full) | Contact Person Name or Position

3. **Residential Address/ Registered Address (If Legal Entity)**

Street Address | Suburb/Region | Town/City/District | Post Code | Country

Postal Address

Same as Residential Address ☐ Yes ☐ No ▸ *If no, please complete the following details:*

Post Office Box | Suburb/Region | Town/City/District | Post Code | Country

Contact Details

Home Phone Number | Work Phone Number | Mobile Number | Facsimile

B. LIFE TO BE INSURED PERSONAL DETAILS

Same as Policy Owner ☐ Yes ☐ No ▸ *If no, please complete the following details:*

Title | First Name | Middle Name | Last Name

Date of Birth (DD/MM/YYYY) | Gender ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ De-facto | Residential Status in Fiji ☐ Resident ☐ Non-resident

C. OCCUPATIONAL DETAILS (To be completed by the Life to be Insured)

What is your current main occupation? | What industry are you employed in? | Date Appointed to Position

DD/MM/YYYY

Describe your major duties (including details as applicable of heights, depths and locations 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

What is your personal income before tax, or profit after business expenses if self employed/own business for the last 12 months?

Is the Insurance being taken to cover a mortgage or loan? ☐ No ☐ Yes ▸ *If yes, please provide details:*

D. COVER DETAILS

Basic Sum Insured	
Riders: (Please tick the rider product you are applying for)	Rider Sum Insured:
☐ PA - Accidental Death Only	
☐ PA 1-26 - Personal Accident plus Death Cover	
☐ PA 2-26 - Personal Accident minus Death Cover	
☐ TPD - Total and Permanent Disability	

E. MEDICAL SECTION (To be completed by the Life to be Insured)

What is your height and weight? Height cm Weight kg

Has your weight altered by 20 kgs in the last 12 months? ☐ No ☐ Yes ▸ *Please give reasons:*

Name of usual Medical Attendant, General Practitioner or Clinic.

Name of usual General Practitioner (GP) or clinic	GP or Clinic Phone Contact	GP or Clinic Postal Address	How long have you been attending this clinic?
			weeks, months, years

What other medical providers have you used in the past?

Have you migrated to Fiji within the last 5 years? ☐ No ☐ Yes ▸ *If yes, please give the following details in previous country of residence:*

Name of usual General Practitioner (GP) or Clinic | GP or ClinicTelephone Contact | GP or Clinic Postal Address

Have you flown or do you intend flying other than as a fare-paying passenger in a commercial aircraft? ☐ No ☐ Yes ▸ *If yes, please provide details by completing the SPS Aviation Form.*

Have you participated or do you intend to participate in any hazardous activity such as racing, skiing or scuba diving, parachuting, mountain climbing or hang gliding? ☐ No ☐ Yes ▸ *If yes, please provide the following details by completing the SPS Hazardous Activities Form.*

F. HEALTH DECLARATION (To be completed by the Life to be Insured)

Have you ever suffered from or ever been diagnosed with or experienced symptoms or treatment for any of the following conditions? ▸ *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 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 eg. skin lesion, melanoma.	☐ No	☐ Yes
12	Sexually transmitted infections including syphillis, gonorrhoea, herpes, warts, hepatitis and 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, 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

Have you 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:*

During the past 5 years have you had any medical examination, advice, treatment, surgical operation, x-ray, electrocardiogram (ECG), CT scan, MRI or any other test or investigation not disclosed in the Health Declaration Questions? ☐ No ☐ Yes ▸ *If yes, please provide details:*

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

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

Name	Relationship to Life to be Insured	Medical Condition	Age at Diagnosis or Death

Females Only: Have you had an abnormal Pap Smear or Mammogram? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Date test done	Test Results

Have you 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		
Alcohol	☐ No	☐ Yes		
Other Drugs or Intoxicants	☐ No	☐ Yes		

G. BENEFICIARY

Beneficiary Type

☐ **Individual** ▸ *If an Individual is selected, please complete the Individual details in G1 below.*

☐ **Legal Entity** ▸ *If a Legal Entity is selected, please complete the Legal Entity details in G2 below:*

1. **Individual Details**

Title	First Name	Middle Name	Last Name	Date of Birth	Relationship to Life to be Insured	Percentage Distribution

2. **Legal Entity Details**

Full Name	Contact Person Name or Position	Registered Address

H. TRUSTEE (Required if Individual Beneficiary is less than 18 years old. Nominated Trustee is to be more than 18 years of age.)

Title | First Name | Middle Name | Last Name

Residential Address

Postal Address

Relationship to Beneficiary

I. PREMIUM PAYMENT DETAILS

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

Direct Payment: ☐ Quarterly ☐ Half-yearly ☐ Annually

Group Scheme: ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Annually

Premium Paid | Receipt Number | Other Payment Channel (attach deposit/Internet slip)

J. 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.

K. DECLARATION AND CONSENT (To be completed by the Proposed Policy Owner and the Life to be Insured)

1. The Proposed Policy Owner and Life to Be Insured **confirms** as follows:
   a. All information provided in this application form and any attachment(s) to this application form are true and correct and I/we declare that I/we have not withheld any information which is material to BSP Health's assessment of the proposed risk.
   b. False or inaccurate information may invalidate the Policy and void the payment of a claim.
   c. **I/we** have satisfied myself with and agree to the terms and conditions of the Policy.
   d. A claim will only be approved when BSP Health is satisfied that policy terms and conditions have been met.
   e. Insurance cover will not commence until BSP Health has accepted this Application and the initial premium is received.
   f. The Policy does not cover any benefit payable in the event of death or disability occurring from war or war services, however defined and including war against terrorism whether war be declared or not, or warlike operation, or civil or political commotion or civil or political unrest or terrorist attack.
   g. I/we consent to BSP Health or its contracted service providers recording any telephone calls between myself and BSP Health and/or its service providers.
   h. I/we agree that a scanned or photocopy of this authority will be as valid as an original.

2. The Life to Be Insured **confirms** as follows:
   a. **I acknowledge** that I have disclosed all health information, including any pre-existing medical conditions.
   b. Where I have indicated that I am non-smoker, **I declare** that I have not smoked cigarettes, cigars, piped tobacco or any other form of tobacco in the past 12 months, and that I have no intention of smoking in the future.
   c. **I understand** that any omission or mis-statement in this declaration could cause an otherwise valid claim to be denied under any policy issued as a result of this application.
   d. **I authorise** any medical practitioner, previous health insurer, any hospital, any medical institution and any other authorities to release to BSP Health or its appointed agent details of any medical history or any other information requested in relation to the Policy or any subsequent claim under the Policy.
   e. **I agree** that a scanned copy or photocopy of this authority will be valid as an original.
3. The Proposed Policy Owner **confirms** as follows:
   a. **I understand** that BSP Health may communicate with me via electronic means such as email, fax, telephone or via a SMS message. 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 documents 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 in paper form for my accounts.
   b. **I understand** that 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.
   c. **Please tick one of the boxes below:**
      ☐ I agree that information contained on this Application be disclosed to other entities within, managed or contracted by BSP Life 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 do not agree that information contained in this Application be disclosed to other entities within, managed or contracted by BSP Life.

Full Name of Life to be Insured	Signature of Life to be Insured	Date
		DD/MM/YYYY

Full Name of Proposed Policy Owner	Signature of Proposed Policy Owner	Date
		DD/MM/YYYY

Full Name of Witness	Signature of Witness	Date
		DD/MM/YYYY

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

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Group Name (if applicable)		Start Date	DD/MM/YYYY
Policy Number		Renewal Date	DD/MM/YYYY
Quotation Number		Received Date	DD/MM/YYYY
Underwriting Decision			