CONTINUATION OF COVER

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

PLEASE READ THESE NOTES:

- The form is to be completed by an eligible Spouse or Dependent on the Policy if the Primary Insured passes away or is ineligible for cover.
- Please also complete the Change Primary Insured form.

Section A : Policy Details

Policy Number:	
Policy Owner Name(s):	

Section B : Continuation of Cover

Reason for Continuation of Cover?

Section C: Declaration

- *I acknowledge that I will take on the responsibility of being the Primary Insured/Policy Owner (if applicable) on the Policy.*
- *I acknowledge that the benefits under the Policy remain the same.*

Full Name:		Signature:		Date:	

For Office Use Only

Checklist: ☐ Impress received stamp on the form.

☐ This form must be completed by an eligible Dependent.

Action Taken:			
	Name	Signature	Date
Received by:			
Authorised by:			