

NON SMOKER DECLARATION

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:

- This form is to be completed for Term Life Insurance Policies ONLY.
- This form is to be completed by the Life Insured for change from smoker rate to non-smoker rate
- This form must be signed by the Policy Owner and the Life Insured.

Section A : Policy Details

Policy Number:

Policy Owner Name:

Life Insured Name:

Section B : Statement to be completed by Life Insured

1. Have you smoked tobacco or any other substance in the last two years? If yes, please advise date last smoked.
2. Have you used any nicotine replacement products in the last two years? If yes, please advise date last used.
3. Do you intend to resume smoking? If yes, please advise when and why.
4. Have you been advised to stop smoking for specific medical reasons? If yes, please provide full details including the name and address of the doctor.
5. Do you have, or has a medical practitioner advised you that you have, a condition caused by or associated with smoking? E.g. emphysema or other breathing problems, heart disease, vascular disease, stroke or cancer. If yes, please provide full details including the name and address of the doctor.

Section C : Declaration

Full Name of Policy Owner:

Signature:

Date:

Full Name of Life Insured:

Signature:

Date:

Section D: For Office Use Only

Checklist: Impress received stamp on the form.

Form completed in full.

Non Smoker Declaration is signed by the Policy Owner and Life Insured.

Action Taken:

Received by:

Name

Signature

Date

Authorised by: