TERM LIFE CLAIM

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

PLEASE READ THESE NOTES

- For a death claim, complete Section E.
- For a Total Permanent Disability claim, complete Section F.
- For a Personal Accident claim, complete Section G.
- For a Critical Illness claim, complete Section H.
- For Total Permanent Disability, Personal Accident and Critical Illness claims, the Medical Provider Statement must be completed and sent to our claims department.

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

A. TYPE OF CLAIM

Policy Number

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, your doctor/medical provider must complete the Medical Provider's Statement on page 5 and post it directly to BSP Health.

B. DETAILS OF LIFE INSURED

Title | First Name | Middle Name | Last Name

Date of Birth

DD/MM/YYYY

Is the Life Insured the Policy Owner? ☐ Yes ▸ Go to Section D ☐ No ▸ Complete Section C and Section D

C. DETAILS OF POLICY OWNER

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

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

D. BENEFICIARY/CLAIMANT DETAILS

Title | First Name | Middle Name | Last Name

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 who Certified Death

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.

Address	Date(s) Consulted
	DD/MM/YYYY

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

Name	Address	From	To	Reason for Confinement
		DD/MM/YYYY	DD/MM/YYYY	

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, your doctor/medical provider must complete the Medical Provider's Statement on page 5 and post it directly to BSP Health.

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 ▸ *If 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 ☐ ▸ *If 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

Are you required to regularly attend any surgery, hospital or clinic for treatment? ☐ No ☐ Yes ▸ *If 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 ▸ *If 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, your doctor/medical provider must complete the Medical Provider's Statement on page 5 and post it directly to BSP Health.

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

Employer Name	Position/Title	Weekly Earnings

5. Are you entitled to any other compensation for this accident from any other company or under the Workmens Compensation Act? ☐ No ☐ Yes ▸ *Please give company's name and contact details below.*

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 below.*

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 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 DD/MM/YYYY

H. CRITICAL ILLNESS CLAIM

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

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 ▸ *If 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 ▸ *If 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/Title	Weekly Earnings

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 ▸ *If Yes, Please give details of the duration you have been disabled or confined.*

From | To

I. CLAIM PAYMENT DETAILS

Bank Name	Bank Account Number	Bank Account Name

J. DECLARATION AND AUTHORISATION (Benefit Payment will only be made if premium payments are in order)

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

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

I understand that BSP Health will use the information provided in this form for purpose of evaluating the claim.

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 Health any information concerning my/the Life Insured's employment, or insurance or any medical information to determine the benefits applicable under the Policy. I confirm that I am duly authorised to provide this statement.

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

Beneficiary/Claimant/ Policy Owner	Signature:	Date: DD/MM/YYYY
		Signed at:

MEDICAL PROVIDER STATEMENT

(To be completed for Total Permanent Disability, Personal Accident and Critical Illness on request by BSP Health)

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

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. What is your patient claiming?
   ☐ Total and Permanent Disability (TPD) ☐ Personal Accident (PA) - Scale ☐ Critical Illness (CI)
2. Patient's Name _____ Patient's Date of Birth DD/MM/YYYY
3. Diagnosis or nature of injury of illness *(please indicate primary and secondary)*
4. Date of injury or first symptoms of illness DD/MM/YYYY
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 ▸ *If 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? ☐ No ☐ Yes ▸ *If Yes, please give details below.*

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:

22. Additional Remarks

23. Medical Provider's Name

Telephone Facsimile

Postal Address

Email

Medical Provider's Signature Date:

Registration No.: Stamp:

INSTRUCTION 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) 326 1787 | Fax: (679) 3308340