DIVING QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, 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

	Full Name:			Date of Birth:	
	Proposal Number:			Dated:	
1	Do you dive for pleasure or for occupational purposes? ▸ If for occupational purposes, please give full details of the nature of your duties and state the name of your employer. ☐ No ☐ Yes				
2	When did you start diving?				
3	What kind of training have you had and with which organization? Please give full details including level of qualification.				
4	What type of diving do you do?				
	Snorkeling ☐	Aqualung ☐	Diving bell ☐	Others (specify) ☐	
5	Are you a member of a diving club or organization? If yes, please state name and address. ☐ No ☐ Yes				
6	Where do you mainly dive?				
	Sea ☐	Oil rigs ☐	Harbour ☐	Lakes ☐	Channels ☐
	rivers ☐	Caves ☐	Other (Please specify):		
7	Previous and future diving activities:				
	Approximate number of dives:				

	Location	To date	Last 12 months	Envisaged next 12 months

8	Please state:	
	Average diving depth:	
	Maximum diving depth	
	Average duration	
	Maximum duration	
9	Do you ever do any saturation diving? ☐ No ☐ Yes ▸ If "Yes", please give details.	

10	Do you dive?	☐ Alone	☐ With a partner	☐ With a group
11	Do you use explosives? ☐ No ☐ Yes ▸ If “Yes”, how often, please give details.			
12	Do you intend to change the scope of your diving activities in the future? ☐ No ☐ Yes ▸ If “Yes”, please give details.			
13	When were you last examined for the purpose of establishing diving fitness?			
	Name of Doctor:			
	Address:			
	Date consulted:		Results:	
14	Have you ever suffered any illness or injury as a result of diving or have you been involved in any accident while diving? ☐ No ☐ Yes ▸ If “Yes” , please give full details of nature of illness/injury, duration, treatment, sequelae, etc			
	Please indicate name address of physician consulted			
	Name of Doctor:			
	Address:			
	Date consulted:			
	Name of Doctor:			
	Address:			
	Date consulted:			

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: