SPINAL DISORDER

(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:	

Please answer the questions below regarding any pain of your neck or the spine, its discs, nerve roots or supporting musculature.

1	Describe the nature and type of pain.
2	Describe the location and radiation of the pain.
3	When did you first experience this pain and was it related to a special event?
4	How frequently does it occur?
5	How long do these attacks last?
6	When last did you experience this pain?
7	How long does the pain normally manifest itself? Does it occur in relation to any activities? ☐ No ☐ Yes ▸ If 'Yes', please give details
8	Are there any other symptoms associated with this pain? ☐ No ☐ Yes ▸ If 'Yes', please give details.
9	Do you still participate in sport? ☐ No ☐ Yes ▸ If 'Yes', to what extent?
10	Have you experienced any incapacity arising from this pain? ☐ No ☐ Yes ▸ If 'Yes', to what extent has it limited your occupational activities?
11	Have you consulted a doctor for this complaint? ☐ No ☐ Yes ▸ If 'Yes', please provide dates.

12	What treatment have you had? Please state names and dosage of tablets and nature and duration of treatment.			
	Name	Dosage of tablets	Nature	Duration of treatment
13	Are you still receiving treatment? ☐ No ☐ Yes			
14	Have you undergone any special investigations, e.g back X-Rays, Scans, etc? ☐ No ☐ Yes ▸ If 'Yes', please provide details.			
15	Please state any further relevant particulars including name and address of personal medical attendant or attendants.			
	Name of Doctor:			
	Address:			
	Date 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: