## SUPPLEMENTARY PERSONAL STATEMENT QUESTIONNAIRE



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 NOTE: Use other side for Bronchitis or Nervous Trouble									
1. When did you first suffer from									
Names and addresses of doctors consulted and exact dates of consultation.									
2. Names and addresses of doctors consulted and exact dates of consultation.									
3. What part of your body was affected (if applicable)									
4. What was the cause? (if applicable)									
5. State: Frequency and / or numl	oer of attacks	Date of attacks	Duration and severity						
	<ul><li>Previously received.</li><li>Now being carried out.</li></ul>	<ul><li>Proposed (eg surgical</li><li>Hospital File No if adm</li></ul>	rgical operation). if admitted.						
7. Give details of any tests made (x-rays, pathology, blood tests, etc.)									
8. State dates and periods off work.									
9. Have you completely recovered	you have been free of all symptoms. Il present condition including any leformity and whether you wear any lich as truss).								
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10. Please give any further relevant information									
I declare that the answers I have given are to the best of my knowledge, true and I have not withheld any material information that may influence the assessment or acceptance of the proposal.  I agree that this form will constitute part of my proposal for life insurance 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:						
	Name in Full		Date:						
Signature of Witness	Signature:		Signed at:						

` ,	and / or					
	Bronchiectasis		When did you first suffer from Bronchitis?			
			Does it result in production of Sputum?			
			When did you last have any treatment from your Doctor?			
		5.	Do you smoke?	☐ No	☐ Yes ➤ If so, how much?	
		6.	Is there any wheezing?	□ No	Yes	
		7.	Do you get breathless with ordinary activities?	□ No	Yes	
		8.	Have you ever had any medical treatment for any chest complaint?	□ No	Yes	
(B)	Nervous Trouble		When did you suffer from the nervous conditions?			
			How many attacks have you had?			
		<ol> <li>Names and addresses of Doctors Consulted –         <ul> <li>(i) Prior to admission to hospital.</li> <li>(ii) Subsequent to discharge.</li> </ul> </li> </ol>	(i)			
			(ii)			
			How long were you under medical supervision and			
		5.	treatment? 5. For how long were you in hospital?			
			When did the medical supervision finally cease?			
		7.	Has there been any recurrence?	□ No	Yes	
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Signature of Life to be In		Sig	Signature:		Date:	
	ure of Life to be Insured				Signed at:	
		Nar	Name in Full		Date:	
Signature of Witness	ure of Witness	Sig	nature:		Signed at:	

1. Do you have a regular cough?

**Bronchitis** 

(A)

Yes

☐ No