Life Insurance Application Form for Life Insured Under 10 Years

PLEASE READ THESE IMPORTANT NOTES

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- This application form must be completed by the Proposed Policy Owner in the presence of a BSP Life Insurance Advisor.
- The Proposed Policy Owner must initial at the bottom of each page acknowledging sections they have filled and made changes on this application form but also to ascertain that full disclosure of details has been made.
- Use a separate sheet(s) for any additional information.

YOUR DUTY OF DISCLOSURE: You are required by law to disclose to BSP Life, every relevant risk or matter which you know or are reasonably expected to know which is relevant to BSP Life's decision to accept the risk of insurance and, if so on what terms. If you do not comply with your duty of disclosure or your non-disclosure is fraudulent, BSP Life may void your contract of insurance at any time from inception or commence legal action against you. If your non-disclosure is innocent, and BSP Life would not have entered into the contract on any terms if the disclosure had been made, BSP Life may void the contract within 3 years of entering into it or reduce the Sum Insured which considers the premium that would have been payable if you had disclosed all relevant matters to BSP Life. This application form is not a contract of insurance but it does form the basis of the contract of insurance. The general terms and conditions of the Policy is available upon request.

Insurance Advisor: ______________________ **QR:** __________

Quality Rating: __________ **Application No:** __________ **Quote No:** __________ **Life ID Number:** __________

SECTION A. PROPOSED POLICY OWNER

(To be completed by the Proposed Policy Owner)

If the Proposed Policy Owner is an Organisation, complete questions 1, 3, 4 and 5. If a Person, complete questions 2 to 5.

1. Organisation Details

Full Name:	Authorised Representative and Position:

2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:

Gender ☐ Male ☐ Female **Date of Birth:** __________

Citizenship/Residency: Fiji Citizen and Resident in Fiji ☐ Fiji Citizen and Not Resident in Fiji ☐ Non-Fiji citizen ☐

Have you, your family members or close associates been entrusted with any prominent public function in Fiji or another country, such as Head of State, Cabinet Minister, Member of Parliament, senior official of a political party, senior government, judicial or military official, senior executive of a state-owned corporation, Permanent Secretary, Department Head OR are you in a senior management position in any international organisation, such as Director, Deputy Director or Board Member? ☐ Yes ☐ No

3. Identification Document Details *(Complete the following for verification of identity)*

Type:	ID Number:	Expiry Date:
Type:	ID Number:	Expiry Date:

4. Contact Detail *(Complete where relevant. At least one number is required)*

Telephone Number(s)

Home:	Work:	Mobile:

What is your Secret Question?
What is the answer to your Secret Question?

Preferred Communication Method

If you provide an email address, you will be sent a link to BSP Life's Customer Self Service Portal where you can access your Policy details and copies of our communication to you, including a copy of your Policy document. Requests for a hard copy of your Policy document must be made in writing or in person. The "free-look" period of 28 days commences on the day your Policy document is emailed to you, posted to you via registered mail or delivered in person, whichever is earlier.

Email Address:	Alternate Email Address:
Postal Address:	
Physical Address: (If not the same as the above)	
Province:	

5. Proposed Policy Owner Bank Account Details

Benefit Payments and Premium Refunds (if any) will be paid to this account

Bank Name:	Bank Account Number:	Bank Account Name:

SECTION B. GROUP DETAILS

(To be completed by the Insurance Advisor)

Group ID Number (if known):	Group Name:	Employee ID Number:

SECTION C. PRIMARY LIFE TO BE INSURED'S DETAILS

(To be completed by the Proposed Policy Owner)

1. Personal Details

Title:	First Name:	Middle Name(s):
Last Name:		Date of Birth: / /

Gender ☐ Male ☐ Female What is your relationship to the Proposed Policy Owner? ____________

Citizenship/Residency Fiji Citizen and Resident in Fiji ☐ Fiji Citizen and Not Resident in Fiji ☐ Non-Fiji citizen ☐

Please fill in the table below:

Measurement		Smoker Status		Has your weight changed by more than (+/-) 20kgs in the last 12 months?
Height cm	Weight kg	Yes ☐	No ☐	Yes ☐ No ☐ ▶ *If Yes, please provide details below:*
Change in weight		Change in kgs		Reason(s) for change
Increase ☐	Decrease ☐			

Grade: ____________ Class: ____________

2. Contact Details

Postal Address:
Physical Address: (If not the same as the above)
Province:

3. Usual Medical Attendant, General Practitioner or Clinic:

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	Period of Consultation

SECTION D. COVER DETAILS

(To be completed by the Insurance Advisor)

1. Primary Life to be Insured:

Product	Sum Insured ($)	Product Term (Years)	Annual Premium ($)	Instalment Premium ($)
Base Product				
Rider 1				
Rider 2				
Rider 3				
Rider 4				
Rider 5				
Total Expected Premium				
Additional Premium Amount[1]				
Total Premium to be Paid				

[1] You can pay an amount in addition to the instalment premium to cater for future circumstances where premiums may be missed. This applies only if the premium is to be paid by Salary Deduction. This is a permanent addition to the premium. Any changes to this amount must be advised in writing.

2. Additional Life to be Insured: Waiver Life Yes ☐ No ☐

▶ *If Yes, please complete the Spouse/Waiver Life to be Insured Application Form.*

SECTION E. HEALTH DECLARATION

(To be completed by the Proposed Policy Owner)

In relation to the Primary Life to be Insured, **You** must disclose details of any Existing Medical Condition(s) or symptoms occurring before the commencement of **Your** policy. When in doubt, please disclose and provide additional information at the end of this form or on a separate sheet.

***Existing Medical Condition** means*

(i) any chronic or ongoing (whether arising from a chronic condition or otherwise) medical or dental condition, Injury, Illness or disease of which the Insured is aware or should reasonably have been aware, and which is medically documented or under investigation prior to commencement of cover, or

(ii) any physical or mental Illness or medical condition (including pregnancy), defect, Injury, Illness or disease of which the Life to be Insured is aware or should reasonably have been aware of or for which treatment, medication, preventative medication, advice, preventative advice or investigation has been received prior to commencement of cover
Where any symptom is the subject of an investigation, that symptom or condition falls within this definition, regardless of whether or not a diagnosis has been made.

*If **You** answer Yes to any of the questions below, please complete the relevant Supplementary Personal Statement Form.*

1. Has the Primary Life to be Insured ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any existing medical condition as described above? Yes ☐ No ☐ *If Yes, please provide full details:*

2. Does he/she have any history of:
(i) Complications at the time or after birth or any physical deformity or defect since birth. Yes ☐ No ☐ *If Yes, please provide the following details:*
(ii) Diabetes, heart valve or any other heart related disorder or cancer.
(iii) Blood disorder (thalassaemia etc), respiratory disorder (asthma, TB etc.), digestive system related disorder (jaundice cirrhosis etc).
(iv) Kidney disorder like protein/blood in urine, or other disorder of joints, muscles, bones like arthritis.
(v) Brain disorder like seizures, paralysis or any other mental/psychiatric illness.

3. Have any of the Primary Life to be Insured's parents, brothers or sisters died or suffered from heart disease including cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, polycystic kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy? Yes ☐ No ☐ *If Yes, please provide the following details:*

Name	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

SECTION F. PREMIUM PAYMENT DETAILS

(To be completed by the Proposed Policy Owner)

Salary Deduction:

If the premium will be paid by Salary Deductions, how often will you be paying premiums?

☐ Weekly ☐ Fortnightly ☐ Semi-Monthly ☐ Monthly

Will the premiums be paid by other means? Yes ☐ No ☐ *If Yes, please provide by which means in the space below:*

How often will you be paying premiums? ☐ Weekly ☐ Fortnightly ☐ Semi-Monthly ☐ Monthly

What is the Payer's Name?

What is the Payer's telephone number or email address?

What is the Payer's EDP / Salary Number?

Direct Deduction:

If the premium will be paid by Direct Deductions, how often will you be paying premiums? ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

If payment is from a Bank, provide the following details in relation to the bank account from which premium payments will be made and complete the relevant Bank Deduction form, if applicable. Otherwise, indicate if payment is via internet banking: Yes ☐ No ☐

Bank Name: | Bank Account Name: | Bank Account Number:

SECTION G. THIRD PARTY DECLARATION

(To be completed by a third party completing the form on behalf of the Proposed Policy Owner/Primary Life to be Insured)

I certify that: (a) the Proposed Policy Owner/Primary Life to be Insured was unable to fill this application form, (b) I have completed this application form using information given to Me by the Proposed Policy Owner/Primary Life to be Insured and (c) the information provided in this application form has been read back to the Proposed Policy Owner/Primary Life to be Insured and explained to him/her in the (Please specify language) ____________ language and the Proposed Policy Owner/Primary Life to be Insured understood its contents.

Name:		Occupation:
Residential Address:		
Telephone: (Home)	Work:	Mobile:
Signature:	Signed at:	Date:

Vetted and Endorsed by Business Relationship Manager

Signature:	Signed at:	Date:

SECTION H. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

(To be completed by the Proposed Policy Owner and Primary Life to be Insured)

Read the details in this section carefully before signing this application form.

I, the Proposed Policy Owner:*

1. **Declare** the information in this application form is provided in the utmost good faith and is true, correct and complete.
2. **Understand** that this application is subject to BSP Life's acceptance, underwriting requirements, payment of premium and any other requirements. Claims must meet Policy terms and conditions.
3. **Understand** that BSP Life relies on the information I have provided in this application form to communicate with me and pay claims. It is my responsibility to inform BSP Life of any changes to my address (email and postal), preferred communication method and bank account details. BSP Life does not accept any responsibility for any communication, or payments made, to my last nominated address or bank account.
4. **Understand and consent** to, subject to applicable privacy laws and policy:
(a) BSP Life, its related entities or agents to collect, disclose, use and store our medical and personal information to assess this application form, process future claims and provide services.
(b) this information being stored, including in electronic form, at BSP Life's registered office as notified to us from time to time and by any of its data storage or software providers (whether in Fiji or elsewhere).
5. **Consent** to email communication with BSP Life:
(a) regarding this application form, my Policy including any notices,
correspondence or communication, which will be issued electronically unless I request otherwise. I further understand that the 28-day free-look period, within which I can cancel my policy and receive a full refund of premiums paid, commences on the date I receive or have been deemed to receive the policy document in electronic or hard copy, whichever is earlier.
(b) For all matters concerning my Policy, including instructions sent via email, where permissible by law and subject to BSP Life's requirements.
6. **Understand** that I am responsible for:
(a) maintaining proper hardware and software to access and view electronic communication
(b) ensuring the security of such information
(c) checking regularly for BSP Life communication
7. **Consent** to my contact information provided in this application form being disclosed to related entities within, managed or contracted by BSP Life or to entities in the BSP Financial Group for:
(a) market research on products and services offered by BSP Life
(b) Marketing products offered from time to time or
(c) Customer surveys

*where the proposed Policy Owner and Life to be Insured are different, the parent/legal guardian of the Life to be Insured also makes these declarations upon signing this application form.

Signature of parent/ legal guardian of life to be insured	Signature Proposed Policy Owner	Signature Witness
Name	Name	Name
Address	Address	Address
Signed at:	Signed at:	Signed at:
Date:	Date:	Date:

Additional Information: *(Please use additional blank paper as may be required.)*

Signature of Business Relationship Manager	Date: