POLICY REINSTATEMENT APPLICATION

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life Customer Services Centre, Ground Floor, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: (679) 331 7000 Call Centre: 132 700 Facsimile: (679) 330 8955 Website: www.bsplife.com.fj

PLEASE READ THESE NOTES:

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- In this form, BSP Life (Fiji) Limited or BSP Health Care (Fiji) Limited, as applicable, is referred to as "BSP Life".
- This form must be completed for the reinstatement of Life Insurance and Term Life policies and must be signed by the Policy Owner and Life Insured(s). The Policy Owner will answer the questions in the Statement of the Life Insured, where the Life Insured is under the age of 16 years. The original policy coverage will not be restored until the policy has been reinstated and premium payments current.
- The second Life Insured must complete a separate form for the reinstatement of the same policy.
- The type, number and expiry date of the identification used to verify the Policy Owner must be noted on the form.
- The form must be submitted with the original policy document (Life Insurance Policies only) if the reinstatement will result in a change in cover and the relevant payment deduction forms – Salary Deduction Form or Request to Alter Existing Deduction from Salary/Wages for salary deduction; respective Bank's Bank Deduction Authority or Bank Client's – Insurance Order Form for bank deduction.
- If any of your personal details require updating, please complete a Change Personal Details form.
- If any of your nominees require updating, please complete a Change Beneficiary form.
- You are obliged to keep us informed of any changes to details in this form to ensure we continue to provide the best service to you.

What you must tell us

- When answering our questions, you have a duty under law to tell us anything known to you, and which a reasonable person in the circumstances, would include in answer to the questions.
- We will use the answers to determine whether to insure you and anyone else to be insured under the policy, and on what terms.

Who needs to tell us

- It is important that you understand you are answering our questions for yourself and anyone else whom you want to be covered by the policy.

If you do not tell us

- If you fail to answer our questions correctly, we may reduce or refuse to pay a claim, or cancel the policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the policy as void.
- When in doubt, please disclose. We treat all information confidentially.

Section A: Policy Details	
Policy Number:	Product Type: ☐ Health ☐ Life

Section B: Policy Owner Details			
1a. Individual Details: *(If Policy Owner 1 is an Individual)*			
Title:	First Name:	Middle Name:	
Last Name:	Date of Birth: *dd/mm/yyyy*	Employment Number:	
Identification: *(type, number and expiry date)*			
1b. Individual Details: *(If Policy Owner 2 is an Individual)*			
Title:	First Name:	Middle Name:	
Last Name:	Date of Birth: *dd/mm/yyyy*	Employment Number:	
Identification: *(type, number and expiry date)*			
1c. Legal Entity Details: *(If Policy Owner is an Entity)*			
Entity Name:			
Authorised Representative Name and Position:			

Section C: Statement by Life Insured
a. Life Insurance Proposal or Application
1. Since the Policy commenced, have you taken out any other life insurance with BSP Life or any other insurance company? ☐ No ☐ Yes ▶If Yes, provide details below *(State insurance company, product type and sum insured)*
2. Since the Policy commenced, has any proposal or application made to BSP Life or any other insurance company for life, disability, accident, medical insurance or revival of Policy on your life been declined, deferred or accepted with additional premiums or on special terms? ☐ No ☐ Yes ▶If Yes, provide details below *(State insurance company, product type and sum insured)*
3. Since the date of signing the original proposal for this policy, has there been any change in your occupation, financial position or annual income, hobbies? ☐ No ☐ Yes ▶ If Yes, provide details below *(State insurance company, product type and sum insured)*

b. Medical Details

1. What is your current:	Height:(cm)	Weight:(kg)

2. Who is your usual Medical Attendant, General Practitioner or Clinic?

Full Name:

Postal Address:

Email Address:

Work:	Home:	Mobile:	Facsimile:

(State details of your last consultation)

Date	Reason	Treatment Received

Have you ever suffered from or ever been diagnosed with the Coronavirus disease specifically caused by the SARS CoV-2 Virus (COVID 19) from anyone of its viral strains (including if you are currently in isolation as a result of being identified as a primary or secondary contact of a person who has tested positive for the Coronavirus disease)?

☐ No ☐ Yes ▶ If Yes, please provide details below.

c. Health Declaration

I hereby agree that the statements below shall form part of my proposal for insurance, and I declare that such statements together with the said proposal and declaration shall be the basis of the Policy between BSP Life and the Policy Owner 'myself'. *(Please answer all questions)*

1. Since the date of signing the original proposal for this policy, have you undergone any of the following:
   a. Medical examinations, advice, treatment of any disease
   b. Operation / Surgery
   c. Pathological examinations like blood tests, x-rays, ECG, CT scan, MRI or any other tests or investigations?

   ☐ No ☐Yes ▶ If Yes, please provide details below and provide copies of investigations done by you.

2. Have you consulted a doctor or specialist after the date of signing the original proposal?

   ☐ No ☐ Yes ▶ If Yes, please provide details below and provide copies of investigations done by you.

3. Are you currently:
   a. Taking any medication or prescription drugs not mentioned earlier?
   b. Suffering from any physical disability, deforming illness or injury that has kept you from working?

   ☐ No ☐ Yes ▶ If Yes, please provide details below and provide copies of investigations done by you.

4. Since the date of signing the original proposal, have you had or are you currently experiencing any health symptoms or complaints for which a Medical Practitioner has not been consulted or treatment received? For example, persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.

   ☐ No ☐Yes ▶ If Yes, please provide details.

Section D: Additional Information

Please provide details below of any other information or material for the assessment of this application.

Section E: Declaration by Policy Owner(s)/Life Insured		
I/We declare that • I/we have completed this application form and confirm that the information is true and correct; • there has been no change in my/our health since the date of my/our original proposal to BSP Life; • the information provided in this application shall be the basis of the insurance contract between BSP Life and myself; I/we understand and agree that my/our proposal for this policy as declared in this application forms the basis of this reinstatement application and the continuance of this Policy.		
Executed by the Policy Owner(s) or Authorised Person *(if Legal Entity)*:		
Full Name of Policy Owner 1:		
Signature/Thumb Print:	Signed at:	Date:
Full Name of Policy Owner 2:		
Signature/Thumb Print:	Signed at:	Date:
Full Name of Life Insured Name:		
Signature:	Signed at:	Date:
Full Name of Insurance Advisor:		
Insurance Advisor/Broker Number:	Sales Unit/Broker:	
Signature:	Signed at:	Date:

For Office Use Only

State reason for approving reinstatement: _____

Checklist:

- ☐ Form is received and date stamped.
- ☐ Supporting documentation is attached to the form.
- ☐ Identification of the Policy Owner has been verified.
- ☐ Change Personal Details form completed (if applicable).
- ☐ Required premiums have been receipted.
  Receipt no: _____
  Amount: $_____
- ☐ Form is fully and correctly completed.
- ☐ Policy Owner is CDD compliant.
- ☐ If Company, form has been properly executed.
- ☐ Change Beneficiary form completed (if applicable).
- ☐ Life Insured Date of Birth has been verified.
- ☐ Change Salesperson application has been processed (if applicable) before the policy reinstatement application is created on BLIS.

Comments:

Received By Department:

Name	Signature	Date
Received / Checked By:		
Authorised By:		

RESET FORM