SHORT FORM - MEDICAL INSURANCE APPLICATION

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

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.

PLEASE COMPLETE ALL DETAILS IN CAPITAL LETTERS AND TICK THE APPROPRIATE BOXES

A. POLICY OWNER DETAILS

Name of Group Scheme

B. PRIMARY INSURED DETAILS

The Primary Insured must complete this section. Please attach Birth Certificate and Passport size photographs for all applicants. Non-compliance with these requirements will delay the issuance of the medical cards.

Title | First Name | Middle Name | Last Name

Date of Birth

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ De-facto

EDP/Pay Number

FNPF Number

Consent to communicate electronically: ☐ Yes ☐ No

Email Address

Residential Address

Street Address | Suburb/Region | Town/City/District | Post Code | Country

Postal Address

Same as Residential Address ☐ Yes ☐ No ▸ *If no, please complete the following details:*

Post Office Box | Suburb/Region | Town/City/District | Post Code | Country

Contact Details

Home Phone Number | Work Phone Number | Mobile Phone Number | Facsimile

What is your current main occupation?

What is the nature of your duties?

C. SPOUSE AND DEPENDENT(S)

First Name	Middle Name	Last Name	Date of Birth	Gender	Relationship to Primary Applicant	Type of Residential Status in Fiji

If a dependent is over 18 years old, please provide proof of full time student status:

D. COVER DETAILS (Please tick the level of cover you are applying for)

Base Plan	Riders					
	Dental and Optical	Allied Health Care	Outpatient Care Plus	Outpatient Care	Medivac Plus (Groups Only)	Medivac Care
☐ Premier Plus	☐	☐	☐	☐		
☐ Premier Care	☐	☐	☐	☐		
☐ Value Care	☐	☐	☐	☐	☐	☐
Other:						

Nominated Preferred Provider (Please nominate a Provider from the BSP Health Preferred Provider List)

Name of nominated General Practitioner (applicable for Outpatient Care and Outpatient Care Plus)

Name of Nominated Preferred Pharmacy (applicable for Outpatient Care and Outpatient Plus)

E. MEDICAL INFORMATION

Name of Life to be Insured	Height (cm)	Weight (kg)	Has your weight altered by more than 20 kgs in the last 12 months?	*If yes, please state reason:*
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	

Name of usual Medical Attendant, General Practitioner or Clinic

Name of Life to be Insured	Name of General Practitioner (GP) or Clinic	GP or Clinic Telephone Contact	GP or Clinic Postal Address	How long have they been attending this GP or Clinic?
				weeks, months, years

Have you, your spouse or any listed dependents migrated to Fiji within the last 5 years? ☐ No ☐ Yes *If yes, please give the following in previous country of residence:*

Health Insurance History

(a) Have you, your spouse or any listed dependents ever had any other medical insurance prior to applying to BSP Health? ☐ No ☐ Yes

If yes, please provide the following details:

Name of Previous Insurer	Insurance Expiry Date	Type of Cover	Reason for Change

(b) Have you or any listed dependent made a health insurance claim in the past? ☐ No ☐ Yes

If yes, please provide the following details:

Name of Life to be Insured	Name of Insurance Company	Reason for Claim	Was the claim accepted and paid
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

(c) Have you, your spouse or any listed dependents had any medical, disability or life insurance application declined, deferred or accepted on special terms? ☐ No ☐ Yes If yes, please provide details

F. HEALTH DECLARATION

An Existing Medical Condition means any chronic or ongoing (whether arising from a chronic Condition or otherwise) medical 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 your policy (if your application is accepted and a Policy Certificate issued), or any physical or mental Illness or medical Condition (including pregnancy related) defect, Injury, Illness or disease of which the 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 Date 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.

Have you, your spouse or any listed dependents ever suffered from, had or been advised to have any surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing any sign or symptom of any illness, medical condition, ailment or disability or existing Medical Condition as described above.? ☐ No ☐ Yes If yes, please provide details

Date	Name of Life to be Insured	Name of General Practitioner (GP) or Clinic	GP or Clinic Telephone Contact	GP or Clinic Postal Address	Condition/Ailment treatment including tests and medication	Duration

G. BENEFICIARY

Title	First Name	Middle Name	Last Name	Date of Birth	Relationship to Life to be Insured

H. DECLARATION AND CONSENT

I understand and acknowledge that

1. the information provided and accompanying this application is true, correct and complete and I will notify BSP Health of any changes.
2. the information BSP Health collects in this application and in the wider application process will be used to consider this application and if approved, consider the specific terms to apply to the policy.
3. I have a duty to disclose to BSP Health anything known to me which a reasonable person in the circumstances, would disclose in this application.
4. Failure to disclose information or the failure to provide full and correct information to BSP Health may make the contract void and if such non-disclosure is fraudulent, BSP Health may take legal action against me.
5. Certain conditions relating to limits, exclusions and waiting periods may apply to the Policy (as agreed to by the Policy Owner). This may include the proviso that cover is not provided for Existing Medical Condition.
6. In relation to any named spouse and listed dependents in this application, I confirm that:
   - I am authorised to complete this application form on their behalf.
   - I am authorised to disclose to BSP Health and receive from BSP Health their personal and health information
   - I am duly authorised to provide the information, acknowledgements, undertaking and authority set out in this form on their behalf

Authorisation

I authorise

1. BSP Health to disclose information about my application to the Policy Owner or Broker.
2. BSP Health or its contracted service providers to record telephone calls between myself and BSP Health and/or the service providers.
3. any doctor, hospital or insurer, employer, service provider, agent or third party to furnish to BSP Health details of my (our) medical history they may require and I confirm that this authorisation also extends to information sought for the spouse and dependents also covered under this policy. This applies at both underwriting and claim time to confirm benefit entitlements under the Policy for myself and the dependents listed on this application.
4. BSP Health to provide a copy of this signed authority as confirmation to external providers when requesting information for the assessment of this application and any claim made under the Policy.
5. **Please tick ONE of the boxes below:**

   ☐ I agree that the information contained on this Application be disclosed to other entities within, managed or contacted by BSP Life for the purpose of marketing products to me that are offered from time to time or for the purpose of customer surveys and authorise those entities to seek access to that information.

   ☐ I do not agree that information contained on this Application be disclosed to other entities within, managed or contracted by BSP Life

Full Name of Primary Applicant	Signature of Primary Applicant	Date
		DD/MM/YYYY

Full Name of Witness	Signature of Witness	Date
		DD/MM/YYYY

FOR OFFICE USE ONLY

Group Name		**Start Date**	DD/MM/YYYY
Policy Number		**Renewal Date**	DD/MM/YYYY
Quotation Number		**Received Date**	DD/MM/YYYY