MEDICAL INSURANCE SUPPLEMENTARY 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: (679) 331 7000 Call Centre: 132 700 Facsimile: (679) 330 8955 Web: www.bsplife.com.fj

Proposal Number

PLEASE READ THESE NOTES:

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- The Primary Applicant must initial all changes made on this application and ensure all details are true and correct.
- The Medical Insurance Application Guide should be used to complete this form.
- This form constitutes part of the Medical Insurance Application or Short Form - Medical Insurance Application.

What you must tell us

- When answering our questions you have a duty under the 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 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 C. SPOUSE AND DEPENDENT(S) *(If a Dependent is over 18 years old, please provide proof of full time student status)*

Title	First Name	Middle Name	Last Name

For sections D-F: A Medical Insurance Supplementary Form must be completed and included for each Life to be Insured (Spouse or listed Dependent(s)) whose details differ from the Primary Applicant. Only complete the section where there is a difference.

SECTION D. COVER DETAILS *(Please tick the level of cover your Spouse or Dependent(s) are applying for)*

Individual Policy	Riders					
Base Product	Dental and Optical Care	Allied Health Care	Premier Outpatient	Outpatient Care Plus	Outpatient Care	Medivac Care
☐ Premier Plus	☐	☐	☐	☐	☐	N/A
☐ Premier Care	☐	☐	☐	☐	☐	N/A
☐ Value Care SP	☐	☐	☐	☐	☐	☐
☐ Value Care	☐	☐	☐	☐	☐	☐
☐ Other						

Group Policy	Riders						
Base Product	Dental and Optical Care	Allied Health Care	Premier Outpatient	Outpatient Care Plus	Outpatient Care	Group Medivac Care	Group Medivac Plus
☐ Group Premier Plus	☐	☐	☐	☐	☐	N/A	N/A
☐ Group Premier Care	☐	☐	☐	☐	☐	N/A	N/A
☐ Group Value Care SP	☐	☐	☐	☐	☐	☐	☐
☐ Group Value Care	☐	☐	☐	☐	☐	☐	☐
☐ Other							

Nominated Provider *(Nominate a Provider from the BSP Health Preferred Provider List. Applicable to Outpatient Care and Outpatient Care Plus riders)*

Name of Nominated General Practitioner	Name of Nominated Pharmacy

SECTION E. MEDICAL DETAILS *(Applicable to your Spouse or Dependent(s))*

1. Height and Weight?

Height (cm)	Weight (kg)	If the weight of your Spouse or listed Dependent(s) has changed by more than 20kgs in the last 12 months please indicate below.	*Please state reason for change:*
		☐ Increase ☐ Decrease	

2. Name of usual Medical Attendant, General Practitioner (GP) or Clinic?

Name of GP or Clinic	Telephone Contact	Postal Address	How long has your Spouse or listed Dependent(s) been visiting this GP or Clinic?

3. What other medical providers have your Spouse or any listed Dependent(s) used in the past?

4. Has your Spouse or any listed Dependent(s) migrated to Fiji within the last 5 years? ☐ No ☐ Yes ▸ *If yes, please provide the following details in reference to their previous country of residence:*

Name of usual GP or Clinic	Telephone Contact	Postal Address

5. Medical Insurance History

(a) Has your Spouse or any listed Dependent(s) ever had any other medical insurance prior to applying to BSP Health? ▸ *If yes, please provide the following details:*

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

(b) Does your Spouse or any listed Dependent(s) have policies with any other medical insurance scheme? ☐ No ☐ Yes ▸ *If yes, please provide details:*

(c) Has your Spouse or any listed Dependent(s) made a medical insurance claim in the past? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Name of Insurer	Reason for Claim	Claim accepted and Paid
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

(d) Have your Spouse or any listed Dependent(s) had any medical, disability or life insurance application declined, deferred or accepted on special terms? ☐ No ☐ Yes ▸ *If yes, please provide details:*

SECTION F. HEALTH DECLARATION

You must disclose details of your Spouse or Dependent(s) Existing Medical Conditions or symptom occurring before the commencement of your policy. When in doubt, please disclose or contact our Customer Call Centre on 132 700 for clarification.

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 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.

Has your Spouse or any listed Dependent(s) 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 for any of the following conditions or any Existing Medical Condition? ▸ *If you answer yes to any of the questions below, please complete the relevant Supplementary Personal Statement Form(s).*

1.	Abnormal blood pressure, angina, chest pain or discomfort, abnormal electrocardiogram (ECG), rheumatic fever/ heart diseases, coronary heart disease, heart attack, heart murmur or any cardiovascular diseases.	☐ No ☐ Yes
2.	Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders.	☐ No ☐ Yes
3.	Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, paralysis, fainting episodes, depression or any type of mental disorders, or epilepsy.	☐ No ☐ Yes

4.	Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the respiratory system, or pleurisy or emphysema.	☐ No ☐ Yes
5.	Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of gastrointestinal tract disorders, or the passing of blood.	☐ No ☐ Yes
6.	Kidney, bladder or prostate diseases, including renal colic or stone, urinary tract infection and passing of blood in the urine.	☐ No ☐ Yes
7.	Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular - skeletal disorders, disc lesion, or other back trouble including lumbago, fibrositis, sciatica or whiplash injury.	☐ No ☐ Yes
8.	Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat.	☐ No ☐ Yes
9.	Diabetes or pancreatic diseases, abnormal blood sugar level, thyroid or any hormonal disorders.	☐ No ☐ Yes
10.	Cancer, tumour, cyst or growth of any type whether it be benign or malignant.	☐ No ☐ Yes
11.	Skin disorder(s) of any type for example, skin lesion and melanoma.	☐ No ☐ Yes
12.	Sexually transmitted infections including syphilis, gonorrhoea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies.	☐ No ☐ Yes
13.	Night sweats, inexplicable weight loss, persistent fever, diarrhoea or swollen glands.	☐ No ☐ Yes
14.	**Males Only** - Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder, urethra.	☐ No ☐ Yes
15.	**Females Only** - Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems.	☐ No ☐ Yes
16.	Any other illnesses, injury, operation, disability or physical abnormality.	☐ No ☐ Yes

17. Has your Spouse or any listed Dependent(s) ever been refused as a blood donor, or had any blood test or other testing services or ever received a blood transfusion; treatment with human blood products or an organ transplant? ☐ No ☐ Yes ▸ *If yes, please provide details:*

18. During the past 5 years have your Spouse or any listed Dependent(s) had any medical examination, advice, treatment, surgical operation, x-ray, ECG, computerised tomography (CT) scan, magnetic resonance imaging (MRI) or any other test or investigation not disclosed in the Health Declaration Questions? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Date	Name of GP or Clinic	GP or Clinic Address	Reasons for Treatment or Test	Test Results

19. Have the parents, brothers or sisters of your Spouse or listed Dependent(s) 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 or Spouse suffered or died from tuberculosis, hepatitis, AIDS or AIDS related conditions? ☐ No ☐ Yes ▸ *If yes, please provide the following details of your family history:*

Family Member Name	Relationship to life to be Insured	Medical Condition	Age at Diagnosis or Death

20. Has your Spouse or any listed Dependent(s) in the last 2 years smoked or ever smoked tobacco or used any other narcotic substance, consumed kava, alcohol or any other drugs or intoxicants? ☐ No ☐ Yes ▸ *If yes, please provide the following details:*

Substance		Type	Daily Quantity
Smoke	☐ No ☐ Yes		
Kava	☐ No ☐ Yes	N/A	*litres/day*
Alcohol	☐ No ☐ Yes		
Other Drugs or Intoxicants	☐ No ☐ Yes		

GENERAL DECLARATION *(To be completed by the Primary Applicant)*

1. **I declare** that to the best of my knowledge, the information provided in this supplementary application and accompanying our application for medical insurance is true, correct and complete and I will notify BSP Health of any changes.
2. **I agree** that this supplementary application constitutes part of our application for medical insurance and that failure to disclose any material fact known to me may invalidate the contract.

Full Name of Primary Applicant

Signature/Thumb Print	Signed at	Date

Full Name of Witness

Signature	Signed at	Date

Full Name of Insurance Advisor/Broker	Insurance Advisor/Broker Number	Sales Unit/Broker

Signature	Signed at	Date