CHANGE PRIMARY INSURED

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

PLEASE READ THESE NOTES:

- This form is to be completed for Medical Insurance Policies ONLY.
- Change Primary Insured Form must be signed by the Policy Owner, a representative of the Policy Owner or Broker.
- Attach a copy of the death certificate of the prior primary insured if the change is a result of the death of that Primary Insured.
- Complete and submit a Continuation of Cover form if a Dependent between the ages of 18-24 years will continue with the current cover if there is no spouse.
- The effective date of change will be a date advised by BSP Health. If the change request arises from the death of the prior Primary Insured, then the effective date of change will be the date of death.

Section A :Policy Details

Policy Number:

Policy Owner Name(s):

Section B :Primary Insured Details

Complete in this section the details of the new Primary Insured.

First Name: Middle Name:

Last Name: Date of Birth: Marital Status:

Residential Address: Postal Address:

Email Address:

Consent to communicate electronically: ☐ Yes ☐ No

Work Phone: Home Phone: Mobile: Facsimile

Reason for change

☐ Request by Policy Owner. (Please specify date: DD/MM/YYYY)	☐ Death of Primary Insured. Attach copy of the death certificate.
☐ Policy Owner is ineligible for cover	☐ Other (please specify)

Section C: Declaration

- *I hereby confirm details above to be correct and request for the change to be applied to the policy.*
- *I understand that BSP Health may communicate with me/the new Primary Insured/Policy Owner via electronic means and by providing the consent in this form, we agree to communicate electronically with BSP Health about this policy and authorise BSP Health to act on instructions it receives electronically.*
- *I am duly authorised to request this change.*

Full Name: Signature: Date:

For Office Use Only

Checklist:
- ☐ Impress received stamp on the form.
- ☐ Form completed for Medical Insurance Policies ONLY.
- ☐ Form must be signed by the Policy Owner, Broker or a representative of the Policy Owner (if the change arises from the Primary Insured passing away). Confirm death certificate attached if change request arises from the death of the prior Primary Insured.
- ☐ Continuation of Cover form if a Dependent between the ages of 18-24 years will continue with the current cover and there is no spouse.

Action Taken:

	Name	Signature	Date
Received by:			
Authorised by:			