POLICY REINSTATEMENT 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

PLEASE READ THESE NOTES:

- This form is to be completed for Reinstatement of Term Life policies ONLY.
- Both the Policy Owner and Life Insured must sign this form.
- The questions below must be answered by the Life Insured.

Section A : Policy Details

Policy Number:

Policy Owner Name(s):

Life Insured Details

Title	First Name	Middle Name	Last Name

Section B : Statement (The Life Insured must complete this section)

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

2. Has a proposal for life, disability, accident or medical insurance been declined, deferred or accepted on special terms with BSP Life or any other company since the commencement of this policy? ☐ No ☐ Yes ▶ If Yes, provide details below

3. Since the Policy commenced, has your occupation changed? ☐ No ☐ Yes ▶ If Yes, provide details below

4. Have you participated or do you intend to participate in any hazardous activity such as racing, skiing or scuba diving, parachuting, mountain climbing or hand gliding? ☐ No ☐ Yes ▶ If Yes, provide details below

5. Have you flown or do you intend to fly other than fare paying passenger in a commercial aircraft?

☐ No ☐ Yes ▶ If Yes, provide details below

6. What is your current:	(a) Height:	cm	(b) Weight:	kg

7. Please state the name of your usual Medical Attendant, General Practitioner or Clinic.

Full Name:	
Postal Address:	
Email Address:	

Work Phone:		Home Phone:		Mobile:		Facsimile:	

Please indicate date and reason of your last consultation.

8. Since the commencement of this policy, have you had any medical examination, advice, treatment for any disease or disorder or any surgical operation, x-ray, electrocardiogram (ECG), CT scan, MRI or any other tests or investigations? ☐ No ☐ Yes ▶ If Yes, provide details below

Section C : Declaration

I understand and agree that:
- *My Application for Term Life as varied by this Application form the basis of this reinstatement application and the continuance of this Policy.*
- *The answers to all questions and declarations on this application are true*.

Full Name of Policy Owner:			
Signature of Policy Owner:		Date:	DD/MM/YYYY
Full Name of Life Insured:			
Signature of Life Insured:		Date:	DD/MM/YYYY
Full Name of Witness:			
Signature of Witness:		Date:	DD/MM/YYYY

For Office Use Only

Checklist: ☐ Impress received stamp on the form.

☐ The Policy Owner and the Life Insured must sign the Application form.

Action Taken:			
	Name	Signature	Date
Received by:			
Authorised by:			