

HYPERTENSION QUESTIONNAIRE

(To be completed by the Life to be Insured)



Please check all details, then complete the relevant areas of the form and return it to:
 BSP Health (Fiji) Limited, Level 5, 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

Full Name:		Date of Birth:	
Proposal Number:		Dated:	
1	State when blood pressure was first diagnosed.		
2	Have you received medical advice? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If "Yes", please provide the name and address of the attending medical person whom you saw for hypertension.		
	Name of Doctor :		
	Address :		
	Date consulted :		
3	How often do you see the medical person?		
4	Treatment advice received and name of drug(s) and required dosage(s) if any.		
5	Has the treatment advice changed since the high blood pressure was diagnosed?		
6	How is your blood pressure monitored and by whom?		
7	Do you know any of your blood pressure readings? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If so, please provide details and dates.		
	Blood Pressure reading	/	Date DD/MM/YYYY
	Blood Pressure reading	/	Date
	Blood Pressure reading	/	Date
	Blood Pressure reading	/	Date
	Blood Pressure reading	/	Date
	Blood Pressure reading	/	Date
8	Do you have any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If "Yes", please describe.		

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: