MENTAL HEALTH QUESTIONNAIRE

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

(To be completed by the Applicant)

Full Name: Date of Birth:

Proposal Number: Dated:

This questionnaire will form part of the application. ▸ *If any questions below are answered "Yes", please supply full details below including dates and names of doctors and institutions where applicable.*

1.	Please give the exact diagnosis. (e.g. depression, schizophrenia, neurosis, phobia, etc):	
2.	Was your condition related to any particular event? ☐ No ☐ Yes ▸ *If Yes, please provide details.*	
3.	What, in your opinion caused the condition?	
4.	a) When did the condition commence?	
	b) Please state the frequency and duration of episodes:	
	c) When was the last episode?	
5.	What is your current treatment? Please state type and dosage of past and present treatment.	
6.	a) Have you ever received hospital treatment for your condition either as an in-patient or out-patient? ☐ No ☐ Yes ▸ *If Yes, please provide dates and duration.*	
	b) Have you ever declined to receive treatment which was recommended by a doctor? ☐ No ☐ Yes ▸ *If so, what are the reasons? Please give dates and details.*	
7.	Has your condition ever led you to harm yourself or express suicidal thoughts or have you ever attempted to commit suicide? ☐ No ☐ Yes ▸ *If Yes, please provide dates and details.*	

8.	Have you ever taken sick leave or time off work due to the mental disorder? ☐ No ☐ Yes ▸ *If Yes, please provide dates and details.*
9.	Does your condition interfere to any degree with your ability to carry out your occupation? ☐ No ☐ Yes ▸ *If Yes, please provide dates and details.*

I declare that the answers I have given are, to the best of my knowledge, true and I have not withheld any material information that may influence the assessment of 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 Signature:	Date: Signed at: