MEDICAL ADMISSION CLAIM FORM

Please complete all 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 Website: www.bsplife.com.fj

PLEASE READ THESE NOTES:

- Please complete all details in BLOCK LETTERS.
- This form must be completed for any medical admission claims.
- Sections A-C must be completed by the Claimant or his/her Representative (i.e. if the claimant is physically disabled or impaired such that the claimant cannot complete the form.)
- Section E must be completed by the Physician or Specialist Doctor.

Section A. Primary Insured Details

Policy Number

Primary Insured's Name[1] *(in full)*

Section B. Claimant's Details *(the claimant is also known as the insured patient)*

Is the Claimant the Primary Insured?

☐ Yes ▶ *If "yes", please proceed to the next section.*
☐ No ▶ *If "no", please fill in this section.*

Claimant's Name[1] *(in full)*

Relationship to Primary Insured

Section C. Medical Information *(the claimant or the claimant's representative is to answer this section on behalf of the claimant)*

1. Do you currently have any cognitive impairment? (i.e. Is there any current deficiency in your mental processes of perception, memory, judgment or reasoning?)

   ☐ No
   ☐ Yes ▶*If "yes", please provide details on what your impairment is, otherwise proceed to question 2.*

2. Have you ever had any psychiatric diagnosis? (i.e. Have you ever been diagnosed with a mental problem or been declared as mentally ill?)

   ☐ No
   ☐ Yes ▶*If "yes", please answer the following questions.*

   (i) What was your psychiatric diagnosis (i.e. mental condition / sickness)? If you are not aware of this, can you at least let us know about where we can obtain information from?

   (ii) When were you diagnosed?

[1] If any of your personal details have changed (e.g. mobile phone number, etc.), please complete the "Change Personal Details" form provided or contact us (see contact details above) or your Insurance Advisor for further assistance.

(iii) Are you currently on any medication?

☐ No

☐ Yes ▶ *If "yes", please answer the following question.*

What medication do you currently take for this?

_____

_____

(iv) Did you previously take medication? If so, please provide details of the medication including the date and year you stopped taking the medication (if at all).

_____

_____

3. When did your medical condition manifest itself (what date did the onset of symptoms occur?)

Day _____ Month _____ Year _____

4. Who have you consulted medically for this condition?

5. Over the past two years, have you been admitted into a hospital / medical institution or treated for any day care procedures?

☐ No

☐ Yes ▶ *If "yes", please provide the following information.*

Name(s) of the Hospital(s)/Institution(s)	Date(s) of Admission	Reason(s) for Admission

Section D. Acknowledgements, Authorisations, Declarations and Disclaimers

This section sets out the basis on which Prior Approvals are provided by BSP Health Care (Fiji) Limited ("**Us**", "**We**" or "**Our**") and must be completed by the Claimant or his/her representative ("**You**" or "**Your**"). Please read and understand the Authorisations, Declarations and Disclaimer carefully before You sign.

Disclaimer

1. When We prior approve Your claim, We may **not** have had sufficient time to carry out Our full due diligence checks on Your medical history. We will assess Your medical insurance risk in order to consider if We would still have provided Prior Approval if We had been made aware of material medical information that was not disclosed to Us when You took out Your policy.
2. If We become aware of material medical information that would have meant that We would not have provided medical insurance cover to You, We will immediately seek reimbursement from You of any cost prior approved and paid or due to be paid, and will not make any further payments to/for You under this Policy.
3. If We become aware of material medical information that would have meant that We would have excluded or placed limitations on Your cover in respect of the condition prior approved, We will immediately seek reimbursement and not make any further payments to You or on Your behalf for any consultations, investigations or treatment, whether medical, surgical or otherwise, directly or indirectly related to, intended for or necessitated by the medical condition claimed for and its related complications on any organ of the body, internal or external, or any physiological system within the body (e.g. vascular system, nervous system, etc.)
4. In the event that (3) above occurs, We will also inform You of key considerations resulting from the underlying implications of the new information, and whether We will cease Your policy or continue it with Special Terms and Conditions imposed by way of Endorsements. You have the right to choose whether or not to continue Your policy given the new Offer of Terms.

Privacy – Use and Disclosure of Your Personal Information

The privacy of Your personal information is important to Us. We will only collect information about You and any others named on this policy that is necessary for the purpose of providing products and services. We may need to disclose Your personal information to other parties, such as health care providers and government authorities.

Acknowledgements, Authorisations and Declarations

You acknowledge that this claim is for Prior Approval of medical services.

You declare that You have disclosed Your full medical history and Your current health status, and to the best of Your knowledge, the information is true, correct and complete.

You understand that You have a duty to disclose to Us anything known to You which a reasonable person in the circumstances would disclose.

You authorise Us to contact third parties including health service providers and medical authorities for clarification of any details relating to this claim.

Beneficiary Agreement

You agree that We may deny a claim due to the reasons stated above. If We deny a claim, You agree to be personally and fully responsible for payment of the medical services.

You also agree that if We have paid or will be paying for any prior approvals made by Us, and it is subsequently found that We would not have provided coverage for the claim, You will reimburse to Us the total amount We have paid to the medical services provider.

You agree to make the co-payment, deductible, or coinsurance as required under Your policy Terms and Conditions.

Signature	Date

Where this form is filled in by your representative, the representative must sign and date the form and print his/her full name and relationship in the space below.

Name of Claimant's Representative	Relationship to Claimant

Please note

All documents attached to this claim must be originals or legally certified copies (i.e. by a Justice of Peace or a Commissioner for Oaths) which will be kept by Us.

- When lodging a claim through the post do not send Your membership card. Please present the membership card when lodging Your claim in person.
- Benefits are not payable if Your premium payments are not up to date.
- Our brochures provide a summary of the main benefits and conditions of Your medical policy.

Section E. Medical Report Information *(To be completed by the treating Physician or Specialist doctor.)*

Please provide factual information and objective opinions on the Claimant.

1. Height _____ m Weight _____ kg

2. (a) How long have you known the claimant?

   _____

   (b) When did you start treating the claimant for his/her medical condition? *Month* _____ *Year* _____

   (c) Date of last visit? Day _____ Month _____ Year _____

3. Diagnosis(es) or presenting complaint / symptoms and duration (in chronological order).

4. Brief relevant medical history associated with the presenting medical condition and the patient's general medical history (in chronological order).

5. Is the claimant currently on any medication(s)?

   ☐ No ☐ Yes ▶ *If "yes", please answer the following questions.*

   (i) What medications are being taken?

   _____

   (ii) When were these medications prescribed?

   _____

   (iii) Are the medications working?

   _____

   (iv) How much longer will the medications need to be taken?

   _____

6. Is there supporting evidence for the Claimant's medical condition? *Please attach originals or legally certified (i.e. by a Justice of Peace or a Commissioner for Oaths) copies of all reports and any other supporting documentation.*

Referring doctor's reports	☐ Yes	☐ No
Laboratory reports	☐ Yes	☐ No
X-ray / CT scan / PET-scan / MRI reports, etc.	☐ Yes	☐ No

Consultants' or Specialists' opinions ☐ Yes ☐ No

Other ☐ Yes ☐ No

7. What is the purpose of the admission?

8. What is the estimated length of admission for inpatient stay by the claimant?

   Months Weeks Days

9. What is the plan of treatment?

10. What is the expected outcome after following the plan of treatment?

11. What is the prognosis of the medical condition for the claimant?

12. Please indicate if the prognosis is adverse or not and whether in your opinion the claimant will live for at least six months or not.

    Prognosis

    Life expectancy months

13. Will follow-up reviews be required?

    ☐ No ☐ Yes ▶ *If "yes" please explain why a review is needed and its importance.*

14. Is it likely the claimant will require further admission in the future?

    ☐ No ☐ Yes ▶ *If "yes" please explain why a readmission may be required.*

15. Please describe any symptoms and functional limitations you have observed about the claimant.

16. Please describe any relevant physical appearance or physical manifestation that is related to the medical condition suffered by the claimant that you have observed.

17. Please describe any physical oddity that has been observed but is **not** related to the claimant's medical condition.

18. Is there any further medical investigation or consultation planned which relates to the claimant's medical condition?

☐ No ☐ Yes ▶ *If "yes, please provide details.*

19. Is any multidisciplinary care required?

☐ No ☐ Yes ▶ *If "yes", please state reasons below and also fill in the table.*

Please provide the contact information for the additional specialist(s) who will attend to the patient.

Specialist's Name	Mobile phone number	Email address

20. Additional information

Section F. Physician / Specialist Doctor's Sign-off and Details

(For official use - Details noted herein must be set up on the system if not done so yet)

Physician / Specialist Doctor's Full Name

Tick option ☐Family Physician ☐Medical Specialty. *Please specify*

Postal Address

Work Phone No. Mobile Phone No.

Email Address Alternate Email Address

Signature Date of Report

Medical Registration No: Stamp