Life Insurance Application Form

PLEASE READ THESE IMPORTANT NOTES

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- This application form must be completed by the Proposed Policy Owner and Primary Life to be Insured in the presence of the Insurance Advisor. The only exception to this is where they are unable to do so as set out in Section J of this application form.
- The Proposed Policy Owner and the Primary Life to be Insured must initial any changes made on this application form.
- If sections in this application form do not have sufficient space, additional information can be noted in the space provided at the end of this application form or on a separate sheet.

YOUR DUTY OF DISCLOSURE

- Before you enter into a contract of insurance with an Insurer, you have a duty to disclose to the Insurer every matter that you know, or could reasonably be expected to know, which is relevant to the Insurer's decision whether to accept the risk of the insurance and, if so on what terms.
- If you fail to comply with your duty of disclosure we may void or vary your contract depending on whether your non-disclosure was fraudulent or not, and the time elapsed.

Insurance Advisor: ______________________ **QR:** __________

SECTION A. PROPOSED POLICY OWNER

(To be completed by the Proposed Policy Owner)

1. Proposed Policy Owner Type

Organisation ☐ Person ☐

► *If Organisation, complete sections 2 and 4. If Person, complete sections 3, 4 and 5.*

2. Organisation Details *(If the Proposed Policy Owner is an Organisation)*

Full Name:

Authorised Representative and Position:

3. Personal Details *(If the Proposed Policy Owner is a Person)*

Title:	First Name:	Middle Name(s):
Last Name:		Date of Birth: / /

Gender Male ☐ Female ☐ Place of Birth ______________________

Citizenship/Residency Fiji Citizen and Resident in Fiji ☐ Fiji Citizen and Not Resident in Fiji ☐ Non-Fiji Citizen ☐

Have you, your family members or close associates been entrusted with any prominent public function in Fiji or another country, such as Head of State, Cabinet Minister, Member of Parliament, senior official of a political party, senior government, judicial or military official, senior executive of a state-owned corporation, Permanent Secretary, Department Head OR are you in a senior management position in any International Organisation, such as Director, Deputy Director or Board Member? Yes ☐ No ☐

Identification Details *(Complete the following identification details for verification purposes)*

Type:	ID Number:	Expiry Date:
Type:	ID Number:	Expiry Date:

4. Contact Details

Telephone Number(s) *(At least one telephone number is required)*

Home Phone Number:	Work Phone Number:
Mobile Phone Number:	Facsimile Number:

What is your Secret Question?

What is the answer to your Secret Question?

Preferred Communication Method Email ☐ Post ☐

Email Address *(If preferred method is Email)*:

Alternate Email Address:

Postal Address

Attention:

Address:

Suburb/Region:

City/District:

Post Code *(if applicable)*:

Country:

Physical Address

Is the Residential or Registered Office Address same as the Postal Address? ▶ ☐ Yes ☐ No *If No, please provide the following details:*

Attention:

Address:

Suburb/Region:

City/District:

Post Code *(if applicable)*:

Country:

5. Nomination of Beneficiaries and Trustee Consent to Act

The nomination of beneficiaries applies if the Proposed Policy Owner is the Primary Life to be Insured. The nomination only applies to the Death Benefit. [1]Type: Enter P for Person or O for Organisation.

Beneficiary Details

Type[1]	Name	Contact Details	Relationship to Policy Owner	Date of Birth	Beneficiary Allocation %
				Total	

Trustee Details and Consent to Act

I consent to be a Trustee for those minor beneficiaries indicated in this section of this Life Insurance Application Form.

Type[1]	Trustee Name	Contact Details	Date of Birth	Applicable Beneficiary	Trustee Signature

SECTION B. GROUP DETAILS

(To be completed by the Insurance Advisor)

Group ID Number *(if known)*:

Group Name:

Employee ID Number:

SECTION C. PRIMARY LIFE TO BE INSURED'S DETAILS

(To be completed by the Primary Life to be Insured)

1. Personal Details *(Complete if the Primary Life to be Insured is different from the Proposed Policy Owner)*

Title:

First Name:

Middle Name(s):

Last Name:

Date of Birth: / /

Gender Male ☐ Female ☐ What is your relationship to the Proposed Policy Owner? ______

Citizenship/Residency Fiji Citizen and Resident in Fiji ☐ Fiji Citizen and Not Resident in Fiji ☐ Non-Fiji citizen

2. Contact Details *(Complete if the Primary Life to be Insured is different from the Proposed Policy Owner)*

Email Address *(if preferred method is Email)*:

Alternate Email Address:

Telephone Number(s) *(At least one telephone number is required)*

Home Phone Number:

Work Phone Number:

Mobile Phone Number:

Facsimile Number:

3. Have you smoked tobacco or any other narcotic substances in the last 2 years? Yes ☐ No ☐

4. What is your Doctor's name? ______

5. What is your current occupation? ______

SECTION D. COVER DETAILS

(To be completed by the Insurance Advisor)

1. Primary Life to be Insured

Product	Sum Insured ($)	Product Term (Years)	Annual Premium ($)	Instalment Premium ($)
Base Product				
Rider 1				
Rider 2				
Rider 3				
Rider 4				
Rider 5				
Total Expected Premium				
Additional Premium Amount[2]				
Total Premium to be Paid				

[2] This allows you to pay an amount in addition to the instalment premium to cater for future circumstances where premiums may be missed. This applies only if the premium is to be paid by Salary Deduction. This is a permanent addition to the premium. Any changes to this amount must be advised in writing.

2. Additional Life(s) to be Insured: Spouse Yes ☐ No ☐ and/or Waiver Life Yes ☐ No ☐

▶ *If Yes, please complete the Spouse/Waiver Life Application Form.*

SECTION E. MEDICAL DECLARATION

(To be completed by the Primary Life to be Insured)

1. What is your height and weight? Height (cm): ____________ Weight (kgs): ____________

▶ *If your weight has changed by more than 20kgs in the last 12 months please indicate below:*

Change in Weight	Change in Kgs	Reason(s) for change.
Increase ☐ Decrease ☐		

2. Have you resided overseas within the last 5 years? Yes ☐ No ☐

▶ *If Yes, please provide the following details in relation to your previous country of residence:*

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	Period of Consultation

3. Do you contemplate residing in or travelling to another country within the next 5 years? Yes ☐ No ☐ ▶ *If Yes, please provide the name of the country and purpose for travel.*

4. Have you flown or do you intend on flying other than as a fare-paying passenger in a commercial aircraft? Yes ☐ No ☐

▶ *If Yes, please provide details by completing the Supplementary Personal Statement Aviation Questionnaire.*

5. Have you participated or do you intend to participate in any hazardous activity such as road racing, skiing or scuba diving, parachuting, mountain climbing or hang gliding? Yes ☐ No ☐ ▶ *If Yes, please provide details by completing the Supplementary Personal Statement Hazardous Questionnaire.*

6. Have you ever resided in a war zone or engaged in war services in that or another country? Was your health affected as a result? Yes ☐ No ☐ ▶ *If Yes, please provide details:*

7. List details of usual Medical Attendant, General Practitioner or Clinic:

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	Period of Consultation

8. Are you on any regular medication or seeing a doctor on a regular basis? Yes ☐ No ☐ ▶ *If Yes, please provide details on type of medication, how long you have been taking this medication and reasons for seeing the doctor on a regular basis.*

SECTION F. HEALTH DECLARATION

(To be completed by the Primary Life to be Insured)

You must disclose details of any Existing Medical Condition(s) or symptoms occurring before the commencement of your policy. When in doubt, please disclose and provide additional information at the end of this form or on a separate sheet.

***Existing Medical Condition** means*

(i) any chronic or ongoing (whether arising from a chronic Condition or otherwise) medical or dental Condition, Injury, Illness or disease of which the Insured is aware or should reasonably have been aware, and which is medically documented or under investigation prior to commencement of cover, or

(ii) any physical or mental Illness or medical Condition (including pregnancy), defect, Injury, Illness or disease of which the Life to be Insured is aware or should reasonably have been aware of or for which Treatment, medication, preventative medication, advice, preventative advice or investigation has been received prior to commencement of cover

Where any symptom is the subject of an investigation, that symptom or Condition falls within this definition, regardless of whether or not a diagnosis has been made.

▶ *If you answer Yes to any of the questions below, please complete the relevant Supplementary Personal Statement Form.*

1. Have you ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any Existing Medical Condition as described above? Yes ☐ No ☐ ▶ *If Yes, please provide full details:*

2. Have you ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any of the following conditions?

(a) Abnormal blood pressure, angina, chest pain or discomfort, abnormal electrocardiogram (ECG), rheumatic fever/heart diseases, coronary heart diseases, heart attack, heart murmur or any cardiovascular diseases. Yes ☐ No ☐

(b) Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders. Yes ☐ No ☐

(c) Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, paralysis, fainting episodes, depression or any type of mental disorders, or epilepsy. Yes ☐ No ☐

(d) Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the respiratory system, or pleurisy or emphysema. Yes ☐ No ☐

(e) Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of gastrointestinal tract disorders, or the passing of blood. Yes ☐ No ☐

(f) Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of blood in the urine. Yes ☐ No ☐

(g) Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular - skeletal disorders, disc lesion, or other back trouble including lumbago, fibrositis, sciatica or whiplash injury. Yes ☐ No ☐

(h) Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat. Yes ☐ No ☐

(i) Diabetes or pancreatic diseases, abnormal blood sugar level, thyroid or any hormonal disorders. Yes ☐ No ☐

(j) Cancer, tumour, cyst or growth of any type whether it be benign or malignant. Yes ☐ No ☐

(k) Skin disorder(s) of any type for example, dermatitis, eczema, psoriasis, skin lesion or melanoma. Yes ☐ No ☐

(l) Sexually transmitted infections including syphilis, gonorrhoea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies. Yes ☐ No ☐

(m) Night sweats, inexplicable weight loss, persistent fever, diarrhoea or swollen glands. Yes ☐ No ☐

(n) **Males Only** - Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder, urethra. Yes ☐ No ☐

(o) **Females Only -** Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems. Yes ☐ No ☐

(p) **Females Only -** Are you pregnant? ▶ *If Yes, please provide the expected date of delivery.* ________________ Yes ☐ No ☐

(q) Any other illnesses, injury, operation, disability or physical abnormality. Yes ☐ No ☐

3. Have you ever been refused as a blood donor, or had any blood test or other testing services or ever received a blood transfusion, treatment with human blood products or an organ transplant? Yes ☐ No ☐

▶ *If Yes, please provide the following details:*

Date	Service Refused/ Treatment Received	Name of Medical Attendant General Practitioner or Clinic	Postal/Email Address	Reason(s)

4. During the past 5 years have you consulted any medical professional or clinic or had any medical examination, advice, treatment, surgical operation, x-ray, ECG, computerised tomography (CT) scan, magnetic resonance imaging (MRI) or any other test, treatment or investigation not disclosed in the Health Declaration Questions? Yes ☐ No ☐

▶ *If Yes, please provide the following details:*

Date	Medical Service	Name of Medical Attendant General Practitioner or Clinic	Postal/Email Address	Reason(s) for Consultation

5. Have any of your parents, brothers or sisters died or suffered from heart disease including cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, polycystic kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy or have any of your sexual Partners suffered or died from tuberculosis, hepatitis, AIDS or AIDS related conditions? Yes ☐ No ☐

▶ *If Yes, please provide the following details:*

Name	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

6. Have you in the last 2 years smoked tobacco or used any other narcotic substance, consumed kava, alcohol or any other non-prescribed drugs or intoxicants? Yes ☐ No ☐ ▶ *If Yes, please provide the following details:*

Type of Substance	Daily Quantity (number or litres per day	Type of Substance	Daily Quantity (number or litres per day

SECTION G. GENERAL DETAILS

(To be completed by the Primary Life to be Insured)

1. Are you married or have you been in a de-facto relationship for more than 2 years? Yes ▢ No ▢

2. Provide the following details of your current main occupation?

Type	Years of Employment	Industry

3. Describe your major duties (including details if applicable of heights, depths and location at which you work and chemicals, gases or any toxic substances used) and provide percentage (%) of time on each major duty. *(Total of percentage must add to 100%)*

4. Provide the following details of your previous occupation.

Type	Years of Employment	Industry

5. What is your personal income before tax, or profit after business expenses if self-employed/own business for the last 12 months? **$** ______________________

6. Is the Insurance being taken to cover a loan? Yes ▢ No ▢ ▶ *If Yes, please provide details:*

7. Have you had any medical or life insurance application declined, deferred, or accepted on special terms?
Yes ▢ No ▢ ▶ *If Yes, please provide details:*

SECTION H. PREMIUM PAYMENT DETAILS

(To be completed by the Proposed Policy Owner)

1. If the premium will be paid by Salary Deduction, how often will you be paying premiums?

☐ Weekly ☐ Fortnightly ☐ Bi-Monthly ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

What is the Payer's Name?

What is the Payer's telephone number or email address?

What is the Payer's EDP / Salary Number?

Additional Premium Amount *(if applicable)* $ *(See Section D Cover Details)*

2. If the premium will be paid by other means, how often will you be paying premiums?

Weekly ☐ Fortnightly ☐ Semi-Monthly ☐ Monthly ☐

3. If the premium will be paid by bank deduction, provide the following details in relation to the bank account from which premium payments will be made:

Bank Name:	Bank Account Name:	Bank Account Number:

SECTION I. PROPOSED POLICY OWNER BANK ACCOUNT DETAILS

(To be completed by the Proposed Policy Owner)

Benefit Payments and Premium Refunds will be paid to this account:

Bank Name:	Bank Account Name:	Bank Account Number:

SECTION J. INSURANCE ADVISOR/THIRD PARTY DECLARATION

(To be completed by the Insurance Advisor/Third Party other than the Proposed Policy Owner/Primary Life to be Insured)

1. I certify that the Proposed Policy Owner/Primary Life to be Insured was unable to fill in this application form.
2. I certify that the information given to Me by the Proposed Policy Owner/Primary Life to be Insured has been accurately and honestly recorded by Me in this application form.
3. I certify that the information filled out in this application form has been read back to the Proposed Policy Owner/Primary Life to be Insured and explained to him/her in the
English ☐ Fijian ☐ Hindi ☐ Other ☐ *(Please specify language)* ____________________
language and the Proposed Policy Owner/Primary Life to be Insured understands its contents.

Name:

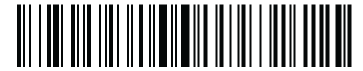
Residential Address:

Occupation:

Signature:	Signed at:	Date:

Vetted and Endorsed by Business Relationship Manager

Signature:	Signed at:	Date:



SECTION K. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

(To be completed by the Proposed Policy Owner and Primary Life to be Insured)

This section sets out the ways in which We can contact You regarding Your application and Policy, the use that We may make of the information that You provide to Us, and the basis upon which You provide that information. Please read and understand the Acknowledgments, Authorisations, Declarations and Disclaimers carefully before You sign this application form.

1. Disclaimers

a. **We** rely on **You** to provide **Us** with medical and personal information that is true, correct and complete and that **You** do not leave out information which would be material and relevant to **Our** decision to offer **You** Insurance Cover.
b. **IF We** later become aware of material information (medical or personal) that would have meant **We** would not have provided insurance Cover to **You**, or would have provided insurance Cover on different terms, **We** reserve the right (subject to law) to avoid **Your** Policy and/or to continue **Your** Policy with changed terms and conditions by way of Endorsements. **You** have the right whether or not to continue **Your** Policy given any new Offer of Terms.
c. **We** will contact **You** at the address **You** provide using **Your** preferred method of communication. **We** will also make payments into **Your** nominated bank account. It is **Your** responsibility to keep **Your** address, preferred method of communication and Bank account details updated. If changes have not been advised, BSP Life will not be held responsible for payments made to the last known authorised bank account or to a third-party account (if payment is authorised by **You**) and **You** indemnify BSP Life to the fullest extent possible from any liability whatsoever arising from the payment of funds into the nominated bank account.

2. Acknowledgements, Authorisations and Declarations

The Proposed Policy Owner and Primary Life to Be Insured understand and confirm as follows:

a. The information provided in this application and any attachment(s) are true, correct and **I/We** declare that **I/We** have not withheld any information which is material to BSP Life's assessment of the application.
b. **I/We** have a duty to BSP Life to disclose in this application anything known to **Me/Us** and failure to disclose information or provide full and correct information to BSP Life may make the contract void. **I/We** understand that BSP Life may take legal action against **Me/Us** for fraudulent non-disclosure.
c. The information BSP Life collects in this application and in the wider application process will be used to consider and process this application and if approved, determine the specific terms to apply to the Policy.
d. Insurance cover will not commence until BSP Life has approved this application and the initial premium is received.
e. A claim will only be approved when BSP Life is satisfied that Policy Terms and Conditions have been met.
f. **I/We** consent to BSP Life and its contracted service providers recording any telephone calls between **Me/Us** and BSP Life and its service providers.

3. Consent to communicate through Email

The Proposed Policy Owner confirms as follows:

a. **I** understand that if **I** have chosen "Email" in the preferred communication method box in Section A, **I** agree to **You** contacting **Me** through email for all matters concerning **My** Policy and **I** authorise BSP Life to communicate with **Me** by email and act on instructions it receives by email (applies to all communications permitted to take place electronically by law).
b. **I** understand it is **My** responsibility to inform BSP Life of any changes to **My** email address and to maintain the appropriate software and hardware to access, view, retrieve, print and save a copy of any documents sent to **Me** electronically.
c. **I** understand and acknowledge that BSP Life is no longer required to send **Me** notices or other documents for **My** Policy in paper form.
d. **I** will ensure that **I** regularly check for notices and other communications from BSP Life and the Email addresses remain current and BSP Life communications to **Me** are not blocked.

4. Consent to Use Contact for Marketing Information Yes ☐ No ☐

The Proposed Policy Owner by ticking Yes, understands and confirms as follows:

a. The contact information contained on this application form be disclosed to other entities within, managed or contracted by BSP Life or to entities in the BSP Group for the purpose of marketing products to **You** that are offered from time to time or for the purpose of customer surveys.

Consent to Third Party Disclosures   Yes ☐ No ☐

The Proposed Policy Owner and Primary Life to Be Insured by ticking Yes, understand and confirm as follows

a. On production of this signed General Declaration, **I/We** authorise BSP Life to collect from and disclose to any relevant third party and these parties to release to BSP Life or its appointed agent any relevant personal and medical information for the assessment of this application or any subsequent claim under the Policy.
b. **I/We** consent to BSP Life and its contracted service providers recording any telephone calls between **Me/Us** and BSP Life and its service providers.
c. **I/We**, agree that a scanned or photocopy of this authority will be as valid as an original.

Primary Life to be Insured:

Signature/Thumbprint:

Signed at:

Date:

Proposed Policy Owner: *(Complete if the Proposed Policy Owner is not the Primary Life to be Insured)*

Signature/Thumbprint:

Signed at:

Date:

Parent/Guardian: *(To be completed if the Proposed Policy Owner is under the age of 18 years)*

I as Parent/Guardian of the Proposed Policy Owner under the age of 18 years, consent to this insurance

Name:

Address:

Signature:

Signed at:

Date:

Witness:

Name:

Address:

Signature:

Signed at:

Date:

Additional Information: