Life Insurance Application Form

ResetForm

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 a BSP Life Insurance Advisor. The only exception to this is where they are unable to do so as set out in Section I 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 spaces provided on this application form or on a separate sheet.

YOUR DUTY OF DISCLOSURE: It is a requirement by law that you disclose to BSP Life, every relevant risk or matter which you know or are reasonably expected to know which is relevant to BSP Life's decision to accept the risk of insurance and, if so on what terms. If you fail to comply with your duty of disclosure or your non-disclosure is fraudulent, BSP Life may void your contract of insurance at any time from inception or commence legal action against you. If your non-disclosure is innocent, BSP Life may choose not to void the contract and reduce any claim you make to the amount that would place it in the position it would have been in if the non-disclosure had not occurred. This application form is not a contract of insurance but it does form the basis of the contract of insurance. The general terms and conditions of the Policy is available upon request.

Insurance Advisor: _____ **Sales Unit:** None

Quality Rating: _____ **Quote No:** _____ **Application No:** _____

Policy Number: _____ **Life ID:** _____

SECTION A. PROPOSED POLICY OWNER

(To be completed by the Proposed Policy Owner)

If the Proposed Policy Owner is an Organisation, complete sections 1, 3, 4 and 6. If a Person, complete sections 2 to 6.

1. Organisation Details

Full Name:	Authorised Representative and Position:

2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:

Gender Male ◯ Female ◯ **Date of Birth** _____ **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 ◯

3. Identification Details *(Complete the following for verification of identity. [1]Complete only if this is for an Organisation.)*

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

What is your Secret Question?[1]
What is the answer to your Secret Question?[1]

4. Contact Details

Telephone Number(s) *(Complete where relevant. At least one number is required)*

Home:	Work:	Mobile:

Preferred Communication Method

If you provide an email address, you will be sent a link to BSP Life's Customer Self Service Portal where you can access your Policy details and copies of our communication to you, including a copy of your Policy document. Requests for a hard copy of your Policy document must be made in writing or in person. The "free-look" period of 28 days commences on the day your Policy document is emailed to you, posted to you via registered mail or delivered in person, whichever is earlier.

Email Address:	Alternate Email Address:

Postal Address

Physical Address

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

5. Nomination of Beneficiaries and Trustee Consent to Act

The nomination of beneficiaries applies if the Proposed Policy Owner is also the Primary Life to be Insured. The nomination only applies to the Death Benefit only. [2]Type: Enter P for Person or O for Organisation.

Beneficiary Details

Type[2]	Name	Contact Details	Relationship to Policy Owner	Date of Birth	Beneficiary Allocation %
None					
None					
None					
Total					0

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[2]	Trustee Name	Contact Details	Date of Birth	Applicable Beneficiary	Trustee Signature
None					

6. Proposed Policy Owner Bank Account Details

Benefit Payments and Premium Refunds will be paid to this account

Bank Name:	Bank Account Number:	Bank Account Name:

SECTION B. GROUP DETAILS

(To be completed by the Insurance Advisor)

Group Name:	Employee ID Number:

SECTION C. PRIMARY LIFE TO BE INSURED'S DETAILS

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

Is the Primary Life to be Insured the same as the Proposed Policy Owner? ◯ Yes ◯ No ▶ *If No, please provide the following details:*

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:

Gender Male ◯ Female ◯ **Date of Birth** _____ **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 where relevant. At least one telephone number is required)*

Home:	Work:	Mobile:

3. 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 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			0.00	0.00
Additional Premium Amount[3]				
Total Premium to be Paid			0.00	0.00

[3] You can 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 Insurance 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): _____

Has your weight changed by more than 20kgs in the last 12 months? Yes ◯ No ◯

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

Change in Weight	Change in kgs	Reason(s) for change.
Increase ◯ Decrease ◯		

2. List of details of usual Medical Attendant, General Practitioner or Clinic and if you have resided overseas in the last 5 years also provide the same details 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 in an aircraft but not as a fare paying passenger on a commercial flight? 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 any country? Yes ◯ No ◯ ▶ *If Yes, was your health affected as a result?* Yes ◯ No ◯ ▶ *If Yes, please provide details:*

7. 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 Conditions. Existing Medical Condition means:

(i) any chronic or ongoing (whether arising from a chronic Condition or otherwise) medical or dental Condition, Injury, Illness of which the Insured is aware or should reasonably have been aware, whether or not it is medically documented or under investigation prior to applying for insurance with BSP Life, or

(ii) any physical or mental Illness or medical Condition (including pregnancy), defect, injury, illness of which the 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 applying for insurance with BSP Life whether disclosed or not and 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.

This definition also includes any Condition(s) that have or would have been discovered as a result of any medical investigation required by BSP Life prior to applying for insurance with BSP Life had all known medical Conditions, and other relevant health information, been disclosed.

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 and 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.* ___ / ___ / 20 ___ 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 of Family Member	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

SECTION G. GENERAL DETAILS

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

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

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

Type (e.g. clerk, police officer, miner, etc.)	Years of Employment	Industry (e.g. tourism, banking, etc.)

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%)*

Major Duties	Percentage of time on duty (%)
TOTAL	0

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

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

6. 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)

Salary Deduction: ◯ Weekly ◯ Fortnightly ◯ Semi-Monthly ◯ Monthly

What is the Payer's Name?

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

What is the Payer's EDP / Salary Number?

Direct Deduction: ◯ Monthly ◯ Quarterly ◯ Semi-Annually ◯ Annually

If payment is from a Bank, provide the following details in relation to the bank account from which premium payments will be made and complete the relevant Bank Deduction form, if applicable. Otherwise, indicate if payment is via internet banking:

Yes ◯ No ◯

Bank Name:	Bank Account Name:	Bank Account Number:

SECTION I. 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 and I have accurately and honestly recorded in this form information given to Me by the Proposed Policy Owner/Primary Life to be Insured.

2. 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 *(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 J. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

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

Read the details in this section carefully before **You** sign this application form.

1. Acknowledgements, Authorisations and Declarations

I/We as the Proposed Policy Owner and Primary Life to be Insured understand and declare as follows:

a. The information provided in this application form is true, correct and complete and **I/We** have fully disclosed all relevant information in the utmost good faith.

b. This application is subject to BSP Life's acceptance, underwriting and other requirements. Insurance cover will not commence until BSP Life has approved this application and the initial premium is received. A claim will only be approved when BSP Life is satisfied that Policy Terms and Conditions have been met.

c. BSP Life will contact **Me/Us** at the address **I/We** provide using **My/Our** preferred method of communication. BSP Life will also make payments into **My/Our** nominated bank account. It is **My/Our** responsibility to keep **My/Our** preferred method of communication, address and bank account details updated. 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 **Me/Us**) and **I/We** indemnify BSP Life to the fullest extent possible from any liability whatsoever arising from the payment of funds into the nominated bank account.

2. Consent to communicate through Email

I the Proposed Policy Owner consent to correspond with BSP Life by "Email" communication regarding this application, any changes or additions to this application including any authorisation by or notifications to **Me** including the receipt by **Me** of the Policy electronically. For all matters concerning **My** Policy, BSP Life can act on instructions received from **Me** by email (applies to all communications permitted to take place electronically by law). **I** further confirm that BSP Life will not send **Me** a hard copy of my Policy, any notices, correspondence or other communication in paper or hard copy format unless otherwise requested by **Me** in writing. **I** am responsible for ensuring that **I** maintain proper software and hardware to access and view electronic communications sent to **Me** by BSP Life and **I** am responsible for the security of information sent to **My** email account. **I** will promptly inform BSP Life of any changes to **My** personal details including changes to residential, postal or email addresses and phone numbers. **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. **I** understand that the free-look period of 28 days provided for by law, within which **I** can cancel **My** policy and receive a full refund of premiums paid, commences on the date **I** receive or have been deemed to receive **My** policy document in electronic or hard copy, whichever is earlier.

3. Consent to Use Contact for Marketing Information ◯Yes ◯No

I the Proposed Policy Owner by ticking Yes, understand and confirm that the contact information contained on this application form may be disclosed to related entities within, managed or contracted by BSP Life or to entities in the BSP Group for the purpose of market research on products and services offered by BSP Life to **Me**, to market other products to **Me** that are offered from time to time or for the purpose of customer surveys; unless otherwise requested by **Me** in writing.

4. Consent to Third Party Disclosures

I/We as the Proposed Policy Owner and Primary Life to Be Insured, understand, consent to and authorise BSP Life and any of its related entities and agents to collect, disclose, use and store any medical and personal information about **Me/Us** for the purposes of assessment of this application, managing and administering the products and services under this Policy. **I/We**, agree that a scan or photocopy of this authority will be as valid as an original. For this purpose, external parties include reinsurers, insurance advisors or brokers, employers, health or medical service providers or any other person or organisation that holds or requires information relevant to **My/Our** insurance or the assessment of any claim. **I/We** further consent to medical and personal information about **Me/Us** being stored at BSP Life's head office at BSP Life Centre, Suva, Fiji and by any of its data storage or software service providers (whether in Fiji or elsewhere) and that it will take reasonable steps to keep such information secure. In the collection, disclosure, use and storage of information, BSP Life will at all times comply with its Privacy Policy and Fiji law. **I/We** acknowledge that BSP Life may be required to disclose **My/Our** personal information if required by law.

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: *(Please use additional blank paper as may be required)*

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