ResetForm

Medical Insurance Application Form

bsp life

PLEASE READ THESE IMPORTANT NOTES

- This form applies where the Proposed Policy Owner is an individual.
- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- Other than as noted at individual sections, the Proposed Policy Owner, who is also the Primary Life to be Insured, must complete this application form and initial any changes made.
- 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.
- The Proposed Policy Owner is completing this form on behalf of all people included in the application. Where the answer for the Spouse or any Dependent is different to the answer for the Proposed Policy Owner, please complete the Individual Supplementary Medical Information Form.

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. However, your duty to disclose is waived if the matter does not increase the risk of the Insurer, is of common knowledge, or is known by the Insurer or in the ordinary course of its business ought to be known.

NON-DISCLOSURE

- If you fail to comply with your duty of disclosure and your non-disclosure is fraudulent, the Insurer may void the Contract at any time. If your non-disclosure is innocent, or the Insurer chooses not to void the contract, the Insurer's liability in respect of a claim is reduced to the amount that would place it in the position it would have been in if the non-disclosure had not occurred. This means your claim can be denied and the non-disclosed condition and its complexities can be excluded from the Policy.

Insurance Advisor: _____

SECTION A. PROPOSED POLICY OWNER

(To be completed by the Proposed Policy Owner)

1. Personal Details

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

Gender Male ◯ Female ◯

Residential Status

Fiji citizen and resident in Fiji ◯ Non-Fiji citizen and Resident Visa ◯ Non-Fiji Citizen and Work Visa greater than 3 years ◯
Non-Fiji Citizen and Work Visa less than 3 years ◯

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

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

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

What is your Secret Question?

What is the answer to your Secret Question?

Identification 1:	**Type**		**ID Number**		**Expiry Date**	
Identification 2:	**Type**		**ID Number**		**Expiry Date**	

3. Proposed Policy Owner Contact Details

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 Physical Address the 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:

4. Proposed Policy Owner Bank Details

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

Bank Name: | Bank Account Name:

Bank Account Number:

SECTION B. PRIMARY LIFE TO BE INSURED'S DETAILS

The Proposed Policy Owner is the Primary Life to be Insured

Has the Primary Life to be Insured smoked tobacco or any other narcotic substances in the last two years? Yes ◯ No ◯

What is your occupation? _____

Primary Life to be Insured's Doctor's Name:

SECTION C. GROUP DETAILS

(To be completed by the Insurance Advisor)

Is the premium to be paid by Salary Deduction? Yes ◯ No ◯

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

Group Name: | Group ID Number (if known):

Employee ID Number:

Is the premium to be paid by Bank Deduction? Yes ◯ No ◯

▶ *If Yes, please 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 D. COVER DETAILS

(To be completed by the Insurance Advisor)

	Riders					
Base Product	Dental and Optical Care	Allied Health Care	Premier Outpatient	Outpatient Care Plus	Outpatient Care	Medivac Care
Premier Plus	☐	☐	☐	☐	☐	n/a
Premier Care	☐	☐	☐	☐	☐	n/a
Value Care SP	☐	☐	☐	☐	☐	☐
Value Care	☐	☐	☐	☐	☐	☐
Other ☐	☐	☐	☐	☐	☐	☐

SECTION E. SPOUSE AND DEPENDENTS

Insured	First Name	Middle Name	Last Name	Date of Birth	Gender	Relationship to Proposed Policy Owner	Residential Status in Fiji
2						Spouse	
3							
4							
5							
6							
7							
8							
9							

SECTION F. GENERAL DETAILS

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

b) What is your current main occupation? _____

c) What industry are you employed in? _____

d) 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.

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

e) Have you had any medical or life insurance application declined, deferred, or accepted on special terms?

Yes ◯ No ◯ ▶ *If yes, please provide details:*

SECTION G. MEDICAL DETAILS

a) Height and Weight

Insured	Height (cm)	Weight (kg)	If your weight has changed by more than 20kgs in the last 12 months please indicate below	Please state reason for changeason(s)
1			Increase ◯ Decrease ◯	
2			Increase ◯ Decrease ◯	
3			Increase ◯ Decrease ◯	
4			Increase ◯ Decrease ◯	
5			Increase ◯ Decrease ◯	
6			Increase ◯ Decrease ◯	
7			Increase ◯ Decrease ◯	
8			Increase ◯ Decrease ◯	
9			Increase ◯ Decrease ◯	

b) 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	For how long did you visit this Medical Attendant,General Practitioner or Clinic

c) Have you, your spouse or any listed dependents ever had any other medical insurance prior to applying to BSP Health?

Yes ◯ No ◯ ▶ *If yes, please provide details:*

d) Do you currently have policies with any other health insurance scheme? Yes ◯ No ◯

► *If yes, please provide details:*

e) Name of usual Medical Attendant, General Practitioner or Clinic?

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	For how long did you visit this Medical Attendant,General Practitioner or Clinic

SECTION H. 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.

This definition also includes any Condition(s) that have or would have been discovered as a result of medical investigation required by BSP Health prior to commencement of cover, had all known medical Conditions been disclosed.

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 or stone, urinary tract infection or 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 ◯

Expected date of delivery _____

(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:*

Family Member Name	Relationship to 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:*

Substance		Type	Daily Quantity
Tobacco/Narcotic Substance	Yes ◯ No ◯		
Kava	Yes ◯ No ◯	Not applicable	Litres/Day
Alcohol	Yes ◯ No ◯		Litres/Day
Other Drugs or Intoxicants	Yes ◯ No ◯		

SECTION I. PROVIDERS

(Only provide this information if Outpatient Care or Outpatient Care Plus is a selected Rider)

Nominated Doctor:	
Nominated Pharmacy:	

SECTION J. MARKETING INFORMATION

Can 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? Yes ◯ No ◯

SECTION K. NOMINATION OF BENEFICIARIES

For individual policies, the nominated beneficiary must be 18 years of age or more.

Beneficiary Details

Beneficiary Name	Contact Details	Date of Birth

SECTION L. PREMIUM PAYMENT DETAILS

Is the premium to be paid by Salary Deduction? Yes ◯ No ◯

▶ **If Yes**

How often will you be paying premiums? 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?

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

▶ ***If No***

How often will you be paying premiums? Quarterly ◯ Semi-Annually ◯ Annually ◯

SECTION M. INSURANCE ADVISOR/THIRD PARTY DECLARATION

(To be completed by the Insurance Advisor/Third Party)

This declaration must be completed if this application form has been filled in by a BSP Life Insurance Advisor or a third party other than the Proposed Policy Owner.

1. I:

Name:

Residential Address:

Occupation:

certify that the Proposed Policy Owner was unable to fill in this application form.

2. I certify that the information given to Me by the Proposed Policy Owner 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 and explained to him/her in the

English ◯ Fijian ◯
Hindi ◯ Other ◯

(Please specify language) _____ language and the Proposed Policy Owner understands its contents.

Signature

Signed at

Date

Vetted and Endorsed by Sales Unit Manager

Signature

Signed at

Date

SECTION N. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

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 below.

Disclaimers

1. **WE** rely on You to provide Us with medical and personal information that is true, correct and complete, that is that the information You provide to Us is true and correct and that You do not leave out information which would be material and relevant to Our decision to offer You Insurance Cover.

2. **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.

3. **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 Health 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 Health to the fullest extent possible from any liability whatsoever arising from the payment of funds into the nominated account.

Acknowledgements, Authorisations and Declarations

The Proposed Policy Owner understand and confirm as follows:

a. The information provided in this application and any attachment(s) are true, correct and **I** declare that **I** have not withheld any information which is material to BSP Health's assessment of the application.
b. **I** have a duty to BSP Health to disclose in this application anything known to **Me** and failure to disclose information or provide full and correct information to BSP Health may make the contract void. **I** understand that BSP Health may take legal action against **Me** for fraudulent non-disclosure.
c. That the information BSP Health 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 Health has approved this application and the initial premium is received.
e. A claim will only be approved when BSP Health is satisfied that Policy Terms and Conditions have been met.
f. **I** consent to BSP Health and its contracted service providers recording any telephone calls between myself and BSP Health and its service providers.

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 Health 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 Health 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 Health 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 Health and the Email addresses remain current and BSP Health communications to **Me** are not blocked.

Proposed Policy Owner

Signature/Thumb Print

Signed at

Date

Witness

Full Name

Signed at

Signature/Thumb Print

Date

Additional Information

SECTION O. CONSENT TO THIRD PARTY DISCLOSURES

The Proposed Policy Owner understands and confirm as follows:

a. On production of this signed General Declaration, **I** authorise BSP Health 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** consent to BSP Health and its contracted service providers recording any telephone calls between myself and BSP Health and its service providers.
c. **I**, agree that a scanned or photocopy of this authority will be as valid as an original.

Proposed Policy Owner

Full Name

Signed at

Signature/Thumb Print

Date

Additional Information

ResetForm