

POLICY REINSTATEMENT APPLICATION

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life Customer Services Centre, 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 and tick the appropriate boxes.
- In this form, BSP Life (Fiji) Limited or BSP Health Care (Fiji) Limited, as applicable, is referred to as "BSP Life".
- This form must be completed for the reinstatement of Life Insurance and Term Life policies and must be signed by the Policy Owner and Life Insured(s). The Policy Owner will answer the questions in the Statement of the Life Insured, where the Life Insured is under the age of 16 years. The original policy coverage will not be restored until the policy has been reinstated and premium payments current.
- The second Life Insured must complete a separate form for the reinstatement of the same policy.
- The type, number and expiry date of the identification used to verify the Policy Owner must be noted on the form.
- The form must be submitted with the original policy document (Life Insurance Policies only) if the reinstatement will result in a change in cover and the relevant payment deduction forms – Salary Deduction Form or Request to Alter Existing Deduction from Salary/Wages for salary deduction; respective Bank's Bank Deduction Authority or Bank Client's – Insurance Order Form for bank deduction.
- If any of your personal details require updating, please complete a Change Personal Details form.
- If any of your nominees require updating, please complete a Change Beneficiary form.
- You are obliged to keep us informed of any changes to details in this form to ensure we continue to provide the best service to you.

What you must tell us

- When answering our questions you have a duty under law to tell us anything known to you, and which a reasonable person in the circumstances, would include in answer to the questions.
- We will use the answers to determine whether to insure you and anyone else to be insured under the policy, and on what terms.

Who needs to tell us

- It is important that you understand you are answering our questions for yourself and anyone else whom you want to be covered by the policy.

If you do not tell us

- If you fail to answer our questions correctly, we may reduce or refuse to pay a claim, or cancel the policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the policy as void.
- When in doubt, please disclose. We treat all information confidentially.

Section A: Policy Details

Policy Number:

Product Type: Health Life

Section B: Policy Owner Details

1a. Individual Details: (If Policy Owner 1 is an Individual)

Title:	First Name:	Middle Name:
Last Name:	Date of Birth: <i>dd/mm/yyyy</i>	Employment Number:
Identification: (type, number and expiry date)		

1a. Individual Details: (If Policy Owner 2 is an Individual)

Title:	First Name:	Middle Name:
Last Name:	Date of Birth: <i>dd/mm/yyyy</i>	Employment Number:
Identification: (type, number and expiry date)		

1b. Legal Entity Details: (If Policy Owner is an Entity)

Entity Name:
Authorised Representative Name and Position:

Section C: Statement by Life Insured

a. Life Insurance Proposal or Application

1. Since the Policy commenced, have you taken out any other life insurance with BSP Life or any other insurance company? No Yes ► If Yes, provide details below (State insurance company, product type and sum insured)

2. Since the Policy commenced, has any proposal or application made to BSP Life or any other insurance company for life, disability, accident, medical insurance or revival of Policy on your life been declined, deferred or accepted with additional premiums or on special terms? No Yes
 ► If Yes, provide details below (*State insurance company, product type and sum insured*)

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3. Since the date of signing the original proposal for this policy, has there been any change in your occupation, financial position or annual income, hobbies? No Yes
 ► If Yes, provide details below (*State insurance company, product type and sum insured*)

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b. Medical Details

1. What is your current: Height:(cm) Weight:(kg)

2. Who is your usual Medical Attendant, General Practitioner or Clinic?

Full Name:

Postal Address:

Email Address:

Work:	Home:	Mobile:	Facsimile:
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(*State details of your last consultation*)

Date	Reason	Treatment Received

c. Health Declaration

I hereby agree that the statements below shall form part of my proposal for insurance and I declare that such statements together with the said proposal and declaration shall be the basis of the Policy between BSP Life (Fiji) Limited ‘the Company’ and the life insured ‘myself’. (*Please answer all questions*)

1. Since the date of signing the original proposal for this policy, have you undergone any of the following:
 a. Medical examinations, advice, treatment of any disease
 b. Operation / Surgery
 c. Pathological examinations like blood tests, x-rays, ECG, CT scan, MRI or any other tests or investigations?
 No Yes ► If Yes, please provide details below and provide copies of investigations done by you.

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2. Have you consulted a doctor or specialist after the date of signing the original proposal? No Yes
 ► If Yes, please provide details below and provide copies of investigations done by you.

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3. Are you currently:

a. Taking any medication or prescription drugs not mentioned earlier?

b. Suffering from any physical disability, deforming illness or injury that has kept you from working?

No Yes ► If Yes, please provide details below and provide copies of investigations done by you.

4. Since the date of signing the original proposal, have you had or currently experiencing any health symptoms or complaints for which a Medical Practitioner has not been consulted or treatment received? For example persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.

No Yes ► If Yes, please provide details below and provide copies of investigations done by you.

Section D: Additional Information

Any other information material for the assessment of this application, kindly provide details below.

Section E: Declaration by Policy Owner(s)/Life Insured

I/We declare that

- as the owner(s) of Policy number stated in this application, do hereby consent to the request reflected in this application;
- all information has been entered by me/us and has been checked by me/us and verified as true and correct;
- since the date of my original proposal to BSP Life, there has been no change in my health;
- the above answers are correct to the best of my knowledge and belief;
- the answers/declarations given above shall be the basis of the insurance contract between BSP Life and myself;
- if the answers/declarations contained herein are untrue, the said insurance contract shall be treated as null and void;

I/we understand and agree that my/our proposal for this policy as varied by this application forms the basis of this reinstatement application and the continuance of this Policy.

Executed by the Policy Owner(s) or Authorised Person (if Legal Entity):

Full Name of Policy Owner 1:

Signature/Thumb Print:	Signed at:	Date:
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Full Name of Policy Owner 2:

Signature/Thumb Print:	Signed at:	Date:
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Full Name of Life Insured Name:

Signature:	Signed at:	Date:
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Full Name of Insurance Advisor:		
Insurance Advisor/Broker Number:	Sales Unit/Broker:	
Signature:	Signed at:	Date:

For Office Use Only

Checklist: State reason for approving reinstatement: _____

<input type="checkbox"/> Form is received and date stamped.	<input type="checkbox"/> Form is fully and correctly completed.
<input type="checkbox"/> Supporting documentation is attached to the form.	<input type="checkbox"/> Policy Owner is CDD compliant.
<input type="checkbox"/> Identification of the Policy Owner has been verified.	<input type="checkbox"/> If Company, form has been properly executed.
<input type="checkbox"/> Change Personal Details form completed (if applicable).	<input type="checkbox"/> Change Beneficiary form completed (if applicable).
<input type="checkbox"/> Required premiums have been receipted	<input type="checkbox"/> Life Insured Date of Birth has been verified.

Receipt no: _____

Amount:\$ _____

Comments:

Received By Department:

Name	Signature	Date
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Received / Checked By:

Authorised By: