Life Insurance Application

Reset Form

PLEASE READ THESE IMPORTANT NOTES

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- Application must be completed by Proposed Policy Owner and Primary Life Insured in the presence of a BSP Life Insurance Advisor. Proposed Policy Owner and Primary Life Insured must initial at the bottom of each page acknowledging sections they have filled and made changes on this application form but also to ascertain full disclosure of details has been made.
- Use a separate sheet(s) for any additional information.

YOUR DUTY OF DISCLOSURE: You are required by law to 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 do not 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, and BSP Life would not have entered into the contract on any terms if the disclosure had been made, BSP Life may void the contract within 3 years of entering into it or reduce the Sum Insured which considers the premium that would have been payable if you had disclosed all relevant matters to BSP Life. 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.

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

Insurance Advisor: _____ **Advisor Code:** _____ **Sales Unit:** _____

SECTION A. PROPOSED POLICY OWNER *(To be completed by the Proposed Policy Owner)*

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

1. Organisation Details

Full Name:	Authorised Representative and Position:

2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ☐ M ☐ F	Date of Birth:	Citizenship/Residency: ☐ Fiji Citizen and living in Fiji ☐ Fiji Citizen but not living 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 ☐ ▶ *If Yes, please provide details.*

3. Identification Document Details *(Complete the following for verification of identity)*

Type:	ID Number:	Expiry Date:
Type:	ID Number:	Expiry Date:
What is your Secret Question?		
What is the answer to your Secret Question?		

4. Contact Details *(Complete where relevant. At least one number is required)*

Home Number:	Work Number:	Mobile Number:

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: *(If not the same as the above)*	

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. It only applies to the Death Benefit.

Beneficiary Name	Beneficiary 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 application form.

Trustee Name	Contact Details	Date of Birth	Applicable Beneficiary	Trustee Signature

6. Proposed Policy Owner Bank Account Details - Benefit Payments and Premium Refunds (if any) 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:

Initial _____

SECTION C. PRIMARY LIFE TO BE INSURED'S DETAILS

(To be completed if the Primary Life to be insured is different from the Proposed Policy Owner)

1. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ○ M ○ F	Date of Birth:	Citizenship/Residency: ○ Fiji Citizen and living in Fiji ○ Fiji Citizen but not living in Fiji ○ Non-Fiji citizen	
Relationship to the Proposed Policy Owner			

2. Contact Details *(Complete where relevant. At least one telephone number is required)*

Home Number:	Work Number:	Mobile Number:

SECTION D. COVER DETAILS *(To be completed by the Insurance Advisor)*

1. Primary Life to be Insured	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[3]				
Total Premium to be Paid				

[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(ves) 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. If Bula Smart, answer questions 4 and 5 only)*

1. Please fill in the table below:

Measurement		Smoker Status		Has your weight changed by more than (+/-) 20kgs in the last 12 months? Yes ○ No ○ ► *If Yes, please provide details below:*
Height cm	Weight kg	Yes ○	No ○	
Change in Weight		Change in kgs		Reason(s) for change.
Increase ○	Decrease ○			

Have you in the last 2 years used or consumed any of the following?

Tobacco Consumption		**Narcotics Consumption**		**Alcohol Consumption**		**Consumption of Kava**		**Consumption of non-prescribed drugs / intoxicants**	
Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
(# per day)		(# or litres per day)		(litres per day)		(litres per day)		(# or litres per day)	

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.*

SECTION F. GENERAL DETAILS *(To be completed by the Primary Life to be Insured. If Bula Smart, go to section H)*

1. 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.)

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

Initial _____

SECTION G. 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.

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 of the following conditions?

Place a ✔ under "Yes" or "No" in the space provided to indicate your appropriate answer.	Yes	No
(a) Diabetes or abnormal sugar level.	◯	◯
(b) High blood pressure or hypertension, or any abnormal blood pressure reading including pregnancy induced hypertension.	◯	◯
(c) Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of blood in the urine.	◯	◯
(d) Cancer, tumour, cyst or growth of any type whether it be benign or malignant. Abnormal pap smear for female or any prostate condition for male.	◯	◯
(e) Coronavirus disease specifically caused by the SARS CoV-2 Virus (COVID 19) from any one of its viral strains (including if you are currently in isolation as a result of being identified as a primary or secondary contact of a person who has tested positive for the Coronavirus disease)	◯	◯
(f) Any other major or chronic illness, medical condition, injury, operation, disability or physical abnormality not mentioned above?	◯	◯
(g) Any diagnostic investigation that would have reflected a medical condition or have been prescribed ongoing medications?	◯	◯

If you have answered YES to any of the questions above, please provide full details below and complete the required Supplementary Personal Statement in relation to the medical illness of the condition disclosed:

Please complete questions (h) to (s) if you have answered yes to any of the above questions or :-

- You are over 40 years of age
- Sum of all Life Insurance base cover (Excl.Single premium) including this application is > $50,000
- Sum of each rider product whether existing or in this application is > $150,000

Place a ✔ under "Yes" or "No" in the space provided to indicate your appropriate answer.	Yes	No
(h) Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders	◯	◯
(i) 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.	◯	◯
(j) Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath and any other disorders of the respiratory system, or pleurisy or emphysema.	◯	◯
(k) 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.	◯	◯
(l) 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.	◯	◯
(m) Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat.	◯	◯
(n) Skin disoder(s) of any type for example, dermatitis, eczema, psoriasis, skin lesion or melanoma.	◯	◯
(o) Sexually transmitted infections including syphilis, gonorrhoea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies.	◯	◯
(p) Night sweats, inexplicable weight loss, persistent fever, diarrhoea or swollen glands.	◯	◯
(q) **Males Only** – Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder and urethra.	◯	◯
(r) **Females Only** – Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems.	◯	◯
(s) **Females Only** – Are you pregnant? If Yes, please provide the expected date of delivery. ____ / ____ / 20____	◯	◯

2. 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/ sexual partner	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

SECTION H. PREMIUM PAYMENT DETAILS *(To be completed by the Proposed Policy Owner)*

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

Name:	Phone:	Email:	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:

Initial _____

SECTION I. THIRD PARTY DECLARATION

(To be completed by a third party completing the form on behalf of the Proposed Policy Owner/Primary Life to be Insured)

I certify that: (a) the Proposed Policy Owner/Primary Life to be Insured was unable to fill this application form, (b) I have completed this application form using information given to Me by the Proposed Policy Owner/Primary Life to be Insured and (c) the information provided 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 understood its contents.

Name:		Occupation:	
Residential Address:			
Telephone (Home):	Work:	Mobile:	
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 signing this application form. I, the Proposed Policy Owner:*

1. **Declare** the information in this application form is provided in the utmost good faith and is true, correct and complete.
2. **Understand** that this application is subject to BSP Life's acceptance, underwriting requirements, payment of premium and any other requirements. Claims must meet Policy terms and conditions.
3. **Understand** that BSP Life relies on the information I have provided in this application form to communicate with me and pay claims. It is my responsibility to inform BSP Life of any changes to my address (email and postal), preferred communication method and bank account details. BSP Life does not accept any responsibility for any communication, or payments made, to my last nominated address or bank account.
4. **Understand and consent** to, subject to applicable privacy laws and policy:
   (a) BSP Life, its related entities or agents to collect, disclose, use and store our medical and personal information to assess this application form, process future claims and provide services.
   (b) this information being stored, including in electronic form, at BSP Life's registered office as notified to us from time to time and by any of its data storage or software providers (whether in Fiji or elsewhere).
5. Consent to email communication with BSP Life:
   (a) regarding this application form, my Policy including any notices, correspondence or communication, which will be issued electronically unless I request otherwise. I further understand that the 28-day free-look period, 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 the policy document in electronic or hard copy, whichever is earlier.
   (b) For all matters concerning my Policy, including instructions sent via email, where permissible by law and subject to BSP Life's requirements.
6. Understand that I am responsible for:
   (a) maintaining proper hardware and software to access and view electronic communication
   (b) ensuring the security of such information
   (c) checking regularly for BSP Life communication
7. Consent to my contact information provided in this application form being disclosed to related entities within, managed or contracted by BSP Life or to entities in the BSP Financial Group for:
   (a) market research on products and services offered by BSP Life
   (b) Marketing products offered from time to time or
   (c) Customer surveys

*where the proposed Policy Owner and Primary Life to be Insured are different, the Primary Life to be Insured also makes these declarations upon signing this application form.

Signature Primary Life Insured	Signature Proposed Policy Owner	Signature Witness
Name:	Name:	Name:
Address:	Address:	Address:
Signed at:	Signed at:	Signed at:
Date:	Date:	Date:
Additional Information: *(Please use additional blank paper as may be required.)*		

SECTION K. ADVISOR DECLARATION

(To be completed by the Advisor who is writing up the proposed Policy Owner)

- I understand that by certifying the identification details of the proposed Policy Owner (as completed within this form above in various sections), I will be held accountable for any breach of Fiji's Financial Transaction Reporting Act 2004.
- I declare that all details captured are true and correct and the identification presented to me is current and appears to be valid.

Signature Insurance Advisor	Date: