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 Proposed Policy Owner)

1. Personal Details

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 ☐

Please fill in the table below:

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

Grade: ____________ Class: ____________

2. Usual Medical Attendant, General Practitioner or Clinic:

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

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[1]				
Total Premium to be Paid				

[1] 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 to be Insured:

Waiver Life Yes ☐ No ☐

▶ If Yes, please complete the Spouse/Waiver Life to be Insured Application Form.

SECTION E. HEALTH DECLARATION

(To be completed by the Proposed Policy Owner)

In relation to 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. Has the Primary Life to be Insured 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. Does he/she have any history of:
(i) Complications at the time or after birth or any physical deformity or defect since birth. Yes ☐ No ☐ ▶ If Yes, please provide the following details:
(ii) Diabetes, heart valve or any other heart related disorder or cancer.
(iii) Blood disorder (thalassaemia etc), respiratory disorder (asthma, TB etc.), digestive system related disorder (jaundice cirrhosis etc).
(iv) Kidney disorder like protein/blood in urine, or other disorder of joints, muscles, bones like arthritis.
(v) Brain disorder like seizures, paralysis or any other mental/psychiatric illness.

+DYH DQ\ RI WKH 3ULPDU\ /LIH WR EH ,QVXUHG·V SDUHQWV EURWKHUV RU VLVWHUV GL cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, polycystic kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy? 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)

SECTION F. PREMIUM PAYMENT DETAILS

(To be completed by the Proposed Policy Owner)

Salary Deduction:

If the premium will be paid by Salary Deductions, how often will you be paying premiums?

☐ Weekly ☐ Fortnightly ☐ Semi-Monthly ☐ Monthly

Will the premiums be paid by other means? Yes ☐ No ☐ ▶ If Yes, please provide by which means in the space below:

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?

Direct Deduction:

If the premium will be paid by Direct Deductions, how often will you be paying premiums? ☐ 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 G. 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 H. 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 WKDW WKLV DSSOLFDWLRQ LV VXEMHFW WR %63 /LIH·V DFFHSWDQFH XQGHUZULWLQJ U
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.
E WKLV LQIRUPDWLRQ EHLQJ VWRUHG LQFOXGLQJ LQ HOHFWURQLF IRUP DW %63 /LIH·V UHJLV
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.
E)RU DOO PDWWHUV FRQFHUQLQJ P\ 3ROLF\ LQFOXGLQJ LQVWUXFWLRQV VHQW YLD HPDLO ZK
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 Life to be Insured are different, the parent/legal guardian of the Life to be Insured also makes these declarations upon signing this application form.

Signature of parent/ legal guardian of life to be 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.)

Signature of Business Relationship Manager	Date:

Initials ________