SECTION C. COVER DETAILS

(To be completed by the Insurance Advisor)

Base Product	Rider(s)
Other(s)	

SECTION D. COVER DETAILS

(To be completed by the Insurance Advisor)

3ULPDU\ /LIH WR EH ,QVXUHG	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				

SECTION E. GENERAL DETAILS

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

$UH \RX PDUULHG RU KDYH \RX EHHQ LQ D GH IDFWR 8QLRQVKLS IRU PRUH WKDQ \HDUV

3URYLGH WKH IROORZLQJ GHWDLOV RI \RXU FXUUHQW PDLQ RFFXSDWLRQ

Type H J FOHUN SROLFH RIILFHU	Years of Employment	Industry H J WRXULVP EDQNLQJ HW

:KDW LV \RXU SHUVRQDO LQFRPH EHIRUH WD[RU SURILW DIWHU EXVLQHVV H[SHQVHV LI VHO

$ _____

,V WKH ,QVXUDQFH EHLQJ Yes No WR▶FRYHU D ORDQ" ,I <HV SOHDVH

+DYH \RX KDG DQ\ PHGLFDO RU OLIH LQVXUDQFH DSSOLFDWLRQ GHFOLQHG GHIHUUHG RU DF

Yes ☐ No ☐ ▶ If yes, please provide details:

SECTION F. MEDICAL DECLARATION

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

3OHDVH ILOO LQ WKH WDEOH EHORZ

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		5HDVRQ V IRU FKDQJH
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)	

/LVW RI GHWDLOV RI XVXDO 0HGLFDO $WWHQGDQW *HQHUDO 3UDFWLWLRQHU RU &OLQLF DQ
DOVR SURYLGH WKH VDPH GHWDLOV WR \RXU SUHYLRXV FRXQWU\ RI UHVLGHQFH

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

+DYH \RX HYHU UHVLGHG LQ D ZDU]RQH" +DYH \RX HYHU HQJDJHG LQ ZDU VHUYLFHV LQ WKD
Yes ☐ No ☐ ▶ If yes, please provide details:

:DV \RXU KHDOWK DIIHFWHG Yes ☐ No ☐ ▶ If yes, please provide details:

'R \RX FRQWHPSODWH UHVLGLQJ LQ RU WUDYHOOLQJ Yes ☐ No ☐ RXWKHU FRXQWU\ ZLWKLQ WKH QH
▶ If Yes, please provide the name of the country and purpose for travel.

+DYH \RX IORZQ RU GR \RX LQWHQG RQ IO\LQJ LQ DQ DLUFUDIW EXW QRW DV D IDUH SD\LQJ
Yes ☐ No ☐ ▶ If Yes, please provide details by completing the Supplementary Personal Statement Aviation Questionnaire.

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 G. HEALTH DECLARATION

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

You MUST GLVFORVH GHWDLOV RI DQ\ ([LVWLQJ 0HGLFDO &RQGLWLRQV ([LVWLQJ 0HGLFDO &RQG

(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 GLDJQRVLV KDV EHHQ PDGH

+DYH \RX HYHU VXIIHUHG IURP RU HYHU EHHQ GLDJQRVHG ZLWK KDG RU EHHQ DGYLVHG WR
ever had or are currently experiencing symptoms or receiving treatmsent for any Existing Medical Condition as described above?
Yes ☐ No ☐ ► If Yes, please provide full details:

+DYH \RX \RXU VSRXVH RU DQ\ RI \RXU OLVWHG GHSHQGHQWV HYHU VXIIHUHG IURP RU HYHU
medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any of the following conditions?

(a) High blood pressure, low blood pressure, chest pain, heart attack, rheumatic fever/heart disease or any other heart related condition or diseases — Yes ☐ No ☐

E /HXNDHPLD KDHPRSKLOLD DQDHPLD RU DQ\ RWKHU IRUP RI EORRG DQG FLUFXODWRU\ GLV — Yes ☐ No ☐

(c) Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, SDUDO\VLV IDLQWLQJ HSLVRGHV GHSUHVVLRQ RU DQ\ W\SH RI PHQWDO GLVRUGHUV RU HS — Yes ☐ No ☐

(d) Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the UHVSLUDWRU\ V\VWHP RU SOHXULV\ RU HPSK\VHPD — Yes ☐ No ☐

(e) Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of [illegible] Yes ☐ No ☐

(f) Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of [illegible] Yes ☐ No ☐

(g) Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular - skeletal disorders, [illegible] Yes ☐ No ☐

(h) Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose [illegible] Yes ☐ No ☐

[illegible] Yes ☐ No ☐

[illegible] Yes ☐ No ☐

[illegible] Yes ☐ No ☐

(l) Sexually transmitted infections including syphilis, gonorrhea, herpes, warts, hepatitis and acquired [illegible] Yes ☐ No ☐

[illegible] Yes ☐ No ☐

(n) **Males Only** - Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, [illegible] 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** - Abnormal cervical smear, abnormal mammogram, Are you pregnant? Yes ☐ No ☐

► If Yes, please provide the expected date of delivery. _____ / _____ / 20 _____

[illegible] Yes ☐ No ☐

[illegible] 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)

[illegible] 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

[illegible] 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)

5. Nomination of Beneficiaries and Trustee Consent to Act

[illegible]

Beneficiary Name	Beneficiary Contact Details	Relationship to Policy Owner	Date of Birth	Beneficiary Allocation %
Total				

Trustee Details and Consent to Act

, FRQVHQW WR EH D 7UXVWHH IRU WKRVH PLQRU EHQHILFLDULHV LQGLFDWHG LQ WKLV VHFWLP

Trustee Name	Contact Details	Date of Birth	Applicable Beneficiary	Trustee Signature

SECTION J. 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: ☐ Weekly ☐ Fortnightly ☐ Semi - Monthly ☐ Monthly

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. 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) _____
ODQJXDJH DQG WKH 3URSRVHG 3ROLF\ 2ZQHU 3ULPDU\ /LIH WR EH ,QVXUHG XQGHUVWRRG LWV F

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. GENERAL DECLARATION

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

I DECLARE THAT:

7KH LQIRUPDWLRQ SURYLGHG LQ WKLV DSSOLFDWLRQ LV FRUUHFW DQG WKDW IDLOLQJ WR GL
IURP LQFHSWLRQ DQG RU OHJDO DFWLRQ ILOHG DJDLQVW PH LQFOXGLQJ UHFRYHU\ RI DQ\ FO

, XQGHUVWDQG WKDW LQVXUDQFH FRYHU XQGHU WKH 3ROLF\ ZLOO QRW FRPPHQFH XQWLO %6
DQG UHFHLYHG SUHPLXP

, FRQVHQW WR

D DQG DXWKRULVH %63 +HDOWK LWV HPSOR\HHV DQG DJHQWV WR

L FROOHFW DQG XVH SHUVRQDO LQIRUPDWLRQ LQ WKLV DSSOLFDWLRQ IRUP RU IURP H[WHUQDO
External parties include reinsurers, employers, providers (medical and pharmaceutical) or any other person or entity that holds or
UHTXLUHV LQIRUPDWLRQ UHOHYDQW WR WKLV DSSOLFDWLRQ RU WKH DVVHVVPHQW RI DQ\ FOD

LL 6WRUH WKH LQIRUPDWLRQ LQ WKLV DSSOLFDWLRQ RU REWDLQHG SXUVXDQW WR D DERYH D
DQG E\ DQ\ RI LWV GDWD VWRUDJH RU VRIWZDUH VHUYLFH SURYLGHUV ZKHWKHU LQ)LML RU

E HPDLO FRPPXQLFDWLRQ ZLWK %63 +HDOWK UHJDUGLQJ WKLV DSSOLFDWLRQ DQG LI DFFHSWH
DFFHVV HPDLO FRPPXQLFDWLRQ IRU %63 +HDOWK , ZLOO SURPSWO\ LQIRUP %63 +HDOWK RI
FKDQJHV WR P\ KHDOWK VWDWXV SULRU WR 3ROLF\ FRPPHQFHPHQW RU %63 +HDOWK DFFHSWL

F P\ FRQWDFW LQIRUPDWLRQ EHLQJ GLVFORVHG WR %63 +HDOWK·V UHODWHG HQWLWLHV RU FR
RU WR PDUNHW RWKHU SURGXFWV WR PH XQOHVV , UHTXHVW RWKHUZLVH LQ ZULWLQJ

Full Name of Primary Insured

Signature/Thumb Print	Signed at
	Date

Full Name of Witness

Signature/Thumb Print	Signed at
	Date