Life Insurance Application Form for Life Insured Under 10 Years

PLEASE READ THESE IMPORTANT NOTES

- Complete all details in BLOCK LETTERS and tick the appropriate boxes.
- Use a separate sheet(s) for any additional information.
- The Proposed Policy Owner and Primary Life Insured must complete this Application in a BSP Life Insurance Advisor's presence

YOUR DUTY OF DISCLOSURE

You must disclose every relevant matter you know, or are reasonably expected to know, which is relevant to BSP Life's decision to accept the risk of insurance and on what terms. BSP Life's remedies for nondisclosure includes avoidance of the policy from inception and reducing the sum insured. This application form is not a contract of insurance, but it does form the basis of the contract of insurance. The Policy's general terms and conditions is available upon request.

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

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 5. If a Person, complete questions 2 to 5.

1. Organisation Details

Full Name:	Authorised Representative and Position:

2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Are you a citizen or resident of Fiji ☐ Yes ☐ No	

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:

Email Address:	Alternate Email Address:
Postal Address:	
Physical Address: *(If not the same as the above)*	

5. 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 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)*

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Citizenship/Residency: ☐ Fiji Citizen and living in Fiji ☐ Fiji Citizen but not living in Fiji ☐ Non-Fiji citizen	

2. What is your relationship to the Primary life to be insured? _____

3. 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				
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. MEDICAL DECLARATION *(To be completed by the Proposed Policy Owner for the Life Insured)*

1. Please fill in the table below:

Measurement			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		
Change in weight		Change in kgs	Reason(s) for change
Increase ☐	Decrease ☐		

Grade: _____ Year: _____

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 F. 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.

3. Have any of the Primary Life to be Insured's 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? 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 G. 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

Name:	Phone:	Email:	EDP/Salary Number:

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 H. 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 I. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

(To be completed by the Proposed Policy Owner)

Read the details in this section carefully before signing this application form. I, the Proposed Policy Owner: *

Declare I have completed this application in good faith and details provided are complete, true and correct. **Understand** that this application is subject to BSP Life's acceptance. **Understand and consent** to: a) BSP Life, its related entities or agents to collect, disclose, use and store our personal information to assess this application, process claims and provide services and b) this information being stored electronically, 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) subject to applicable law and policy.	**Consent** to email communication with BSP Life **Consent** to my contact information being disclosed to related entities within the BSP Financial Group for: a) Market research on products and services. b) Marketing products offered from time to time or c) Customer surveys

Signature Proposed Policy Owner:	Signature Witness:
Name:	Name:
Address:	Address:
Signed at:	Signed at:
Date:	Date:

Additional Information: (Please use additional blank paper as may be required.)

Signature of Business Relationship Manager	Date: