Medical Insurance Application

YOUR DUTY OF DISCLOSURE
It is a requirement by law that you disclose to BSP Health, every relevant risk or matter which you know or are reasonably expected to know which is relevant to BSP Health's decision to accept the risk of insurance and, if so on what terms. If you fail to comply with your duty of disclosure or your non-disclosure is fraudulent, BSP Health may void your contract of insurance at any time from inception or commence legal action against you.
If your non-disclosure is innocent, BSP Health may choose not to void the contract and reduce any claim you make to the amount that would place it in the position it would have been in if the non-disclosure had not occurred. 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.

Insurance Advisor: _____ **QR:** _____

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

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

1. 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.*

2. 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?		

3. 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)*	

4. Nomination of Beneficiaries
The nomination of beneficiaries applies if the Proposed Policy Owner is also the Primary Life to be Insured. It only applies to the Funeral Asssistance Benefit. *Only spouse/primary insured above 18 years old.*

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

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 Name:	Employee ID Number:

SECTION C. INSURED'S DETAILS (SPOUSE AND DEPENDENTS)

Insured	First Name	Middle Name	Last Name	Date of Birth	Gender	* Relationship to Proposed Policy Owner	Residential status in Fiji
1							
2							
3							
4							
5							
6							
7							
8							

* Please specify whether de-facto or spouse.

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

1.

Base Product	Rider(s)
Other(s)	

2. Providers *(only provide this information if Outpatient Care Plus is a selected rider)*

Nominated Doctor:	
Nominated Pharmacy:	

SECTION E. MEDICAL DECLARATION *(To be completed by all the lives to be insured under this policy)*

1. Height and Weight (Primary insured, spouse and dependents)

Insured	Height (cm)	Weight (kg)	If your weight has changed by more than 20kgs in the last 12 months please indicate below	Please state reason for change(s)
1			Increase ☐ Decrease ☐	
2			Increase ☐ Decrease ☐	
3			Increase ☐ Decrease ☐	
4			Increase ☐ Decrease ☐	
5			Increase ☐ Decrease ☐	
6			Increase ☐ Decrease ☐	
7			Increase ☐ Decrease ☐	
8			Increase ☐ Decrease ☐	
9			Increase ☐ Decrease ☐	

2. Have you, your spouse or any listed dependents in the last 2 years smoked tobacco or used any other narcotic substance, consumed kava, alcohol or any other non-prescribed drugs or intoxicants? Yes ☐ No ☐ ▶ *If Yes, please provide details below:*

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)	(# of litres per day)	(litres per day)	(litres per day)	(# of litres per day)	

3. Have you, your spouse and any of your listed dependents, resided overseas within the last 5 years? Yes ☐ No ☐

▶ *If yes, please provide the following details in relation to your previous country of residence:*

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	For how long did you visit this Medical Attendant, General Practitioner or Clinic

4. Have you, your spouse or any listed dependents ever had any other medical insurance prior to applying to BSP Health? Yes ☐ No ☐

▶ *If yes, please provide details:*

5. Do you, your spouse or any of your listed dependents currently have policies with any other health insurance scheme? Yes ☐ No ☐

▶ *If yes, please provide details:*

6. What is your spouse or any listed dependents usual Medical Attendant, General Practitioner or Clinic?

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	For how long did you visit this Medical Attendant, General Practitioner or Clinic

SECTION F. OCCUPATIONAL DETAILS *(To be completed by the Primary Life to be Insured)*

1. Are you married or have you been in a de-facto relationship for more than 2 years? Yes ☐ No ☐

2. 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.)

3. Have you, your spouse or any listed dependents had any medical or life insurance application declined, deferred, or accepted on special terms? Yes ☐ No ☐ ▶ *If Yes, please provide details.*

SECTION G. HEALTH DECLARATION *(To be completed by all the lives to be insured under this policy)*

You **MUST** disclose details of any medical or dental condition, injury or illness of which you are aware or should reasonably have been aware, whether it is medically documented or under investigation and regardless of whether a diagnosis has been made, prior to completing this form.

1. Have you, your spouse or any of your listed dependents, 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?

If you answer YES to any of the questions below, please complete the required Supplementary Personal Statement.	*Yes*	*No*
(a) Abdominal problem or stomach-ache, gastritis or ulcer, gallstones or liver problem, hernia or haemorrhoids or passing blood		
(b) Abnormal blood pressure whether low or high, high or very low cholesterol		
(c) AIDS or HIV infection or any other sexually transmitted infection including warts, syphilis, gonorrhoea or herpes		
(d) Anaemia, Leukemia, Haemophilia or any other form of blood or circulatory and venous disorders including varicose veins		
(e) Asthma, bronchitis, Tuberculosis, coughing or spitting out blood, shortness of breath or any other disease of the respiratory system		
(f) Arthritis, gout, cartilage or ligament injury, bone fractures or any other musculoskeletal disorder or vertebral conditions like back or neck pain		
(g) Brain or nervous disorders, headache or migraine, numbness or tingling, tremors or fainting episodes or blurry vision or epilepsy		
(h) Cancer, tumour or cyst whether benign or malignant, breast condition or abnormal pap smear for females		
(i) Defect in sight, hearing and speech or any other abnormality of the eyes, ears, nose and throat		
(j) Depression or mental disorder including stress, anxiety, panic attack, post-traumatic stress, behavioural or nervous disorder		
(k) Diabetes or abnormal blood sugar or glucose in urine		
(l) Heart attack, chest pain or abnormal electrocardiogram (ECG) or recent angiogram or a bypass surgery, or others including RHD		
(m) Kidney or bladder problem including stones, urinary tract infection or blood in urine or any prostate conditions for males		
(n) Physical disability whether congenital or acquired, any amputation, stroke or paralysis or any other genetic disorder		
(o) Skin disorder of any type, bacterial, viral or fungal infection, boil or cellulitis or any allergic reaction		
(p) Females only — Are you pregnant?		
(p) Females only — If yes, provide Expected date of delivery ____ / ____ / _____		
(q) Any other major or chronic illness, medical condition, injury, operation, disability or physical abnormality not mentioned above?		
(r) Any diagnostic investigation that would have reflected a medical condition or have been prescribed ongoing medications?		

2. Have any of you or your spouse's parents, brothers or sisters died or suffered from any Non-Communicable Diseases (NCD), like diabetes, heart attack or stroke or any hereditary or genetically related condition like polycystic kidney dieases, cystic fibrosis, cancer, mental disorder, muscular dystrophy, tuberculosis, hepatitis, AIDS or AIDS related conditions.

Yes ☐ No ☐ ▶ *If Yes, please provide details below:*

Name of Family Member	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

3. Have you, your spouse or any of your listed dependents ever been refused as a blood donor, or had any blood test or other testing services or ever received a blood transfusion, treatment with human blood products or an organ transplant?

Yes ☐ No ☐ ▶ *If Yes, please provide details below:*

Date	Service Refused/ Treatment Received	Name of Medical Attendant, General Practitioner or Clinic	Postal/Email Address	Reason(s)

4. Have you, your spouse or any of your listed dependents during the past 5 years have you consulted any medical professional or clinic or had any medical examination, advice, treatment, 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 details below:*

Date	Medical Service	Name of Medical Attendant, General Practitioner or Clinic	Postal/Email Address	Reason(s) for Consultation

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

Salary Deduction (for PSC ONLY): ☐ Fortnightly

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: ☐ 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 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:	Date:

Vetted and Endorsed by Business Relationship Manager

Signature:	Signed:	Date:

SECTION J. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS *(To be completed by the Primary Life to be Insured)*

Read the details in this section carefully before signing this application form. I, the Primary Life to be Insured:

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 Primary Life Insured:	Signature Witness:
Name:	Name:
Address:	Address:
Signed at:	Signed at:
Date:	Date: