

Term Life Insurance Application Form



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.

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:
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2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Are you a citizen or resident of Fiji <input type="radio"/> Yes <input type="radio"/> 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.**

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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: <i>(If not the same as the above)</i>		

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 %

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:
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SECTION B. 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: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Citizenship/Residency: <input type="checkbox"/> Fiji Citizen and living in Fiji <input type="checkbox"/> Fiji Citizen but not living in Fiji <input type="checkbox"/> 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:
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SECTION C. 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				

SECTION D. GENERAL 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. Is the Insurance being taken to cover a loan? Yes ☐ No ☐ ► If Yes, please provide details:

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4. Have you had any medical or life insurance application declined, deferred, or accepted on special terms?

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

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SECTION E. MEDICAL DECLARATION *(To be completed by the Primary Life to be Insured)*

1. 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 <input type="checkbox"/>	No <input type="checkbox"/>
Change in Weight		Change in kgs		Reason(s) for change.	
Increase <input type="checkbox"/> Decrease <input type="checkbox"/>					
Have you in the last 2 years used or consumed any of the following?					
Tobacco Consumption		Narcotics Consumption		Alcohol Consumption	
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(# per day)		(# or litres per day)		(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. Have you ever resided in a war zone? Have you ever engaged in war services in that or another country?

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

4. Was your health affected as a result? Yes ☐ No ☐ ► If yes, please provide details:

5. 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.

6. 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.

7. 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. OCCUPATIONAL DETAILS (Questions 1-4 to be completed. For Total and Permanent Disability rider (TPDR), complete questions 1-7).

1. Current main occupation

Type (e.g. clerk, police officer, miner, etc.)	Hours Worked per Week	Industry (e.g. tourism, banking, etc.)

2. Do you have a secondary occupation? ☐ Yes ☐ No ► If Yes, please provide details below:

Type (e.g. clerk, police officer, miner, etc.)	Hours Worked per Week	Industry (e.g. tourism, banking, etc.)	Income before tax from the last 12 months

3. Describe your exact duties, the tasks involved (including details as applicable of heights, depth and locations at which you work, and chemicals, gases or any toxic substances used) and provide the percentage of time spent on each duty and the percentage of time that each duty requires manual or physical work, including driving.

Exact Duties	% of time on each duty	% that requires manual or physical work, including driving

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

5. Do you hold a professional or trade qualification relevant to your occupation? ☐ Yes ☐ No ► If Yes, please provide details below:

6. Do you intend to change your occupation or duties in the next two years, or have you been advised you are pending redundancy at your place of employment? ► If Yes, please provide details below:

7. Have you been in your current position for less than 5 years? (If yes, please provide details)

From (MM/YYYY)	To (MM/YYYY)	Occupation	Employer

SECTION G. HEALTH DECLARATION (To be completed by all 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. Have you 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.

(a) Abdominal problem or stomach-ache, gastritis or ulcer, gallstones or liver problem, hernia or haemorrhoids or passing blood	Yes	No
(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?	
	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 your 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 diseases, cystic fibrosis, cancer, mental disorder, muscular dystrophy, tuberculosis, hepatitis, AIDS or AIDS related conditions.

Yes ☐ No ☐ ► If Yes, please provide the following details:

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

3. Have you 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 the following details:

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

4. Have you 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 the following details:

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: ☐ 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

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:
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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:
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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: *

<p>Declare I have completed this application in good faith and details provided are complete, true and correct.</p> <p>Understand that this application is subject to BSP Life's acceptance.</p> <p>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.</p>	<p>Consent to email communication with BSP Life</p> <p>Consent to my contact information being disclosed to related entities within the BSP Financial Group for:</p> <p>a) Market research on products and services.</p> <p>b) Marketing products offered from time to time or</p> <p>c) Customer surveys</p>
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*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: