Group Term Life Insurance Application (Long Form)

BSP Life PNG Limited, Level 2, Waigani Banking Centre | Section 34, Allotment 6&7, Klinki Street, Waigani Drive
P O Box 78, Port Moresby, National Capital District, Papua New Guinea.
Telephone: (675) 3056214 Email: servicebsplife@bsp.com.pg

PLEASE READ THESE IMPORTANT NOTES

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- The Proposed Policy Owner and the Primary Life to be Insured must initial any changes made on this Application Form.
- If sections in this Application Form do not have sufficient space, additional information can be noted in the space provided at the end of this application form, or on a separate sheet and attach.

YOUR DUTY OF DISCLOSURE

- Before you enter into a contract of insurance with an Insurer, you have a duty to disclose to the Insurer every matter that you know, or could reasonably be expected to know, which is relevant to the Insurer's decision whether to accept the risk of the insurance and, if so on what terms.
- If you fail to comply with your duty of disclosure, we may void or vary your contract depending on whether your non-disclosure was fraudulent or not, and the time elapsed.

NON-DISCLOSURE·

- If you fail to comply with your duty of disclosure and your non-disclosure is fraudulent, the Insurer may void the contract at any time. If your non-disclosure is innocent, and the Insurer would not have entered into the contract on any terms if the disclosure had been made, the Insurer may void the contract. An Insurer who is entitled to void the contract may, elect not to void it, but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

Account Manager: | **Quote No.:**

SECTION A. PROPOSED POLICY OWNER DETAILS

(To be completed by the Proposed Policy Owner)

1. Organisation Details

Full Name:

Authorised Representative and Position:

2. Contact Details

Telephone Number(s) *(At least one telephone number is required)*

Work Phone Number:	**Home Phone Number:**
Mobile Phone Number:	**Facsimile Number:**

Email Address *(If preferred method is Email)*:

Alternate Email Address

Postal Address

Attention:	**Address:**
Town:	**Province**
Post Code *(If applicable)*	**Country**

Physical Address

Is the Physical Address the same as the Postal Address? ☐ Yes ☐ No ►*If No, please provide the following details.*

Attention:	**Section and Lot:**
Street:	**Town/Province**
Post Code *(if applicable)*	**Country**

3. Proposed Policy Owner Bank Details

Benefit Payments and Premium Refunds will be paid to this account.

Bank Name:	**Bank Account Number:**

Bank Account Name:

BSP Classification: Internal Use Only

SECTION B. PRIMARY LIFE TO BE INSURED'S DETAILS

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

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: ☐ PNG Citizen and Resident in PNG ☐ PNG Citizen and Not Resident in PNG ☐ Non-PNG Citizen and resident in PNG

2. **Contact Details**

Email Address:

Telephone Number(s) *(At least one telephone number is required)*

Work Phone Number:	**Home Phone Number:**
Mobile Phone Number:	**Facsimile Number:**

SECTION C. COVER DETAILS

(To be completed by the Account Manager)

Primary Life to be Insured

Product	Sum Insured (PGK)	Annual Premium (PGK)	Instalment Premium (PGK)
Death Benefit (Base Product)			
Accidental Death Benefit 75			
Accidental Total and Permanent Disability			
Personal Accident Scale:			
Total Premium to be Paid			

Additional Cover for Spouse: ☐ Yes ☐ No ►*If Yes, please complete the Spouse Group Term Life Application Form.*

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 *(For example Clerk, Flight Attendant, Engineer, Miner, etc.)*	Years of Employment	Industry

3. Provide the following details of your previous occupation

Type *(For example Clerk, Flight Attendant, Engineer, Miner, etc.)*	Years of Employment	Industry

BSP Classification: Internal Use Only

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

☐ Yes ☐ No ► *If Yes, please provide details.*

SECTION E. MEDICAL DECLARATION

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

1. What is your height and weight? Height (cm): _____ Weight (kgs): _____

► *If your weight has changed by more than 20kgs in the last 12 months please indicate below.*

Change in Weight	Change in Kgs	Reason(s) for change
☐ Increase ☐ Decrease		

2. Do you contemplate travelling to another country within the next 12 months? ☐ Yes ☐ No ► *If Yes, please provide the name of the country and purpose of travel.*

Country	Purpose

3. Have you flown or do you intend on flying other than as a fare-paying passenger in a commercial aircraft?

☐ Yes ☐ No ► *If Yes, please provide details by completing the Supplementary Personal Statement Aviation Questionnaire.*

4. 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.*

5. Have you ever resided in a war zone or engaged in war services in that or another country? Was your health affected as a result?

☐ Yes ☐ No ► *If Yes, please provide details.*

6. List details of usual Medical Provider(s):

Name of Medical Provider	Telephone Number	Postal/Email Address	Period of Consultation

7. Are you on any regular medication or seeing a Medical Provider on a regular basis?

☐ Yes ☐ No ► *If Yes, please provide details on type of medication, how long you have been taking this medication and reasons for seeing the Medical Provider on a regular basis.*

SECTION F. HEALTH DECLARATION

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

You must disclose details of any [1]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.

*If you answer **Yes** to any of the questions below, please complete the relevant Supplementary Personal Statement Form.*

1. Have you 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 in the footnote below?

   ☐ Yes ☐ No ► *If Yes, please provide full details.*

2. Have you 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?

(a)	Abnormal blood pressure, angina, chest pain or discomfort, abnormal electrocardiogram (ECG), rheumatic fever/heart diseases, coronary heart diseases, heart attack, heart murmur or any cardiovascular diseases.	☐ Yes	☐ No
(b)	Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders.	☐ Yes	☐ No
(c)	Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, paralysis, fainting episodes, depression or any type of mental disorders, or epilepsy.	☐ Yes	☐ No
(d)	Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the respiratory system, or pleurisy or emphysema.	☐ Yes	☐ No
(e)	Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of gastrointestinal tract disorders, or the passing of blood.	☐ Yes	☐ No
(f)	Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of blood in the urine.	☐ Yes	☐ No
(g)	Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular – skeletal disorders, disc lesion, or other back trouble including lumbago fibrositis, sciatica or whiplash injury.	☐ Yes	☐ No
(h)	Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat.	☐ Yes	☐ No
(i)	Diabetes or pancreatic diseases, abnormal blood sugar level, thyroid or any hormonal disorders.	☐ Yes	☐ No
(j)	Cancer, tumour, cyst or growth of any type whether it be benign or malignant.	☐ Yes	☐ No
(k)	Skin disorder(s) of any type for example, dermatitis, eczema, psoriasis, skin lesion or melanoma.	☐ Yes	☐ No
(l)	Sexually transmitted infections including syphilis, gonorrhoea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies.	☐ Yes	☐ No
(m)	Night sweats, inexplicable weight loss, persistent fever, diarrhoea or swollen glands.	☐ Yes	☐ No
(n)	**Males Only** – Prostrate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder and urethra.	☐ Yes	☐ No

[1] ***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 of 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.

(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** – Are you pregnant? ► *If Yes, please provide expected date of delivery.* _____ ☐ Yes ☐ No

(q) Any other illnesses, injury, operation, disability or physical abnormality. ☐ Yes ☐ No

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 Provider	Postal or Email Address	Reason

4. During the past 5 years have you consulted any Medical Provider 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 Provider	Postal or Email Address	Reason for Consultation

5. Have any of your 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 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	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

6. Have you in the last 2 years smoked tobacco or used any other narcotic substance, betel nut, consumed alcohol or any other non-prescribed drugs or intoxicants?

☐ Yes ☐ No ► *If Yes, please provide the following details.*

Type of Substance	Daily Quantity *(number or litres per day)*	Type of Substance	Daily Quantity *(number or litres per day)*

SECTION G. ACCOUNT MANAGER/THIRD PARTY DECLARATION

(To be completed by the Account Manager or Third Party)

This declaration must be completed if this Application Form has been filled in by the Account Manager or a Third Party other than the Primary Life to be Insured.

1. **I certify** that the Primary Life to be Insured was unable to fill in this application form.
2. **I certify** that the information given to **Me** by the Primary Life to be Insured has been accurately and honestly recorded by **Me** in this Application Form.
3. **I certify** that the information filled out in this Application Form has been read back to the Primary Life to be Insured and explained to him/her in the

   ☐ English ☐ Tok Pisin ☐ Other *(Please specify language)* _____

   language and the Proposed Primary Life to be Insured understands its contents.

Name
Address
Occupation

Signature:	Signed at:	Date:

Vetted and Endorsed by Team Leader

Signature:	Signed at:	Date:

SECTION H. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

(To be completed by the Proposed Policy Owner and the Primary Life to be Insured)

This section sets out the ways in which **We** can contact **You** regarding **Your** application and Policy, the use that **We** may make of the information that **Yo**u provide to **Us**, and the basis upon which **You** provide that information. Please read and understand the Acknowledgements, Declarations and Disclaimers carefully before **You** sign this Application Form.

1. Disclaimers

a. **We** rely on **You** to provide **Us** with medical and personal information that is true, correct and complete and that **You** do not leave out information which would be material and relevant to **Our** decision to offer **You** Insurance Cover.
b. **IF We** later become aware of material information (medical or personal) that would have meant **We** would not have provided insurance Cover to **You**, or would have provided insurance Cover on different terms, **We** reserve the right (subject to law) to avoid **Your** Policy and/or to continue **Your** Policy with changed terms and conditions by way of endorsements. **You** have the right whether or not to continue **Your** Policy given any new Offer of Terms.
c. **We** will contact **You** at the address **You** provide using **Your** preferred method of communication. It is **Your** responsibility to keep **Your** address, preferred method of communication and Bank account details updated. If changes have not been advised, BSP Life will not be held responsible for payments made to the last known authorised bank account or to a third-party account (if payment is authorised by **You**) and **You** indemnify BSP Life to the fullest extent possible from any liability whatsoever arising from the payment of funds into the nominated bank account.

2. Acknowledgements, Authorisations and Declarations

The Proposed Policy Owner and Primary Life to be Insured understands and confirm as follows:

a. The information provided in this application and any attachment(s) are true, correct and **I/We** declare that **I/We** have not withheld any information which is material to BSP Life's assessment of the application.
b. **I/We** have a duty to BSP Life to disclose in this application anything known to **Me/Us** and failure to disclose information or provide full and correct information to BSP Life may make the contract void. **I/We** understand that BSP Life may take legal action against **Me/Us** for fraudulent non-disclosure.
c. The information BSP Life collects in this application and in the wider application process will be used to consider and process this application and if approved, determine the specific terms to apply to the Policy.
d. Insurance cover will not commence until BSP Life has approved this application and the initial premium is received.
e. A claim will only be approved when BSP Life is satisfied that Policy Terms and Conditions have been met.

3. Consent to Communicate Through Email

The Proposed Policy Owner confirms as follows:

a. **I** understand that if **I** have chosen "Email" in the preferred communication method box in Section A, **I** agree to BSP Life contacting **Me** through email for all matters concerning **My** Policy and **I** authorise BSP Life to communicate with **Me** by email and act on instructions it receives by email (applies to all communications permitted to take place electronically by law).
b. **I** understand it is **My** responsibility to inform BSP Life of any changes to **My** email address and to maintain the appropriate software and hardware to access, view retrieve, print and save a copy of any documents sent to **Me** electronically**.**
c. **I** understand and acknowledge that BSP Life is no longer required to send **Me** notices or other documents for **My** Policy in paper form**.**
d. **I** will ensure that I regularly check for notices and other communications from BSP Life and the email addresses remain current and BSP Life communicates to **Me** are not blocked**.**

4. Consent to Use Contact for Marketing Information ☐ Yes ☐ No

The Proposed Policy Owner and the Primary Life to be Insured by ticking Yes, understands and confirms as follows:

a. The contact information contained on this application form be disclosed to other entities within, managed or contracted by BSP Life or to entities in the BSP Group for the purpose of marketing products to **Me/Us** that are offered from time to time or for the purpose of customer surveys.

5. Consent to Third Party Disclosures ☐ Yes ☐ No

The Proposed Policy Owner and the Primary Life to be Insured, by ticking "Yes", understands and confirms as follows:

a. On production of this signed General Declaration, **I/We** authorise BSP Life to collect from and disclose to any relevant third party and these parties to release to BSP Life or its appointed agent any relevant personal and medical information for the assessment of this application or any subsequent claim under the Policy.
b. **I/We** consent to BSP Life and its contracted service providers recording any telephone calls between **Me/Us** and BSP Life and its service providers.
c. **I/We** agree that a scanned or photocopy of this authority will be as valid as an original.

Primary Life to be Insured:

Signature/Thumbprint	Signed at:
	Date:

Proposed Policy Owner (Authorised Person):

Signature/Thumbprint	Signed at:
	Date:

Witness:

Signature/Thumbprint	Signed at:
	Date:

Name in Full

Address