Life Insurance Application Form for Spouse to be Insured

PLEASE READ THESE IMPORTANT NOTES

- Please complete all details in BLOCK LETTERS and tick the appropriate boxes.
- This supplementary application form must be completed by the Proposed Policy Owner and the Spouse to be Insured in the presence of the Insurance Agent. The only exception to this is where they are unable to do so as set out in Section F of this application form.
- The Proposed Policy Owner and the Spouse 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.

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.

Insurance Agent: _____ **Sales Unit:** _____ **Quality Rating:** _____ **Quote No:** _____

SECTION A. SPOUSE TO BE INSURED'S DETAILS

(To be completed by the Spouse to be Insured)

1. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ☐ M ☐ F	Date of Birth:	Citizenship/Residency: ☐ PNG Citizen living in PNG ☐ PNG Citizen not living in PNG ☐ Non-PNG citizen	

2. Identification Document Details *(Complete the following for verification of identity. Identification must meet date of birth requirement)*

Type:	ID Number:	Expiry Date:
Type:	ID Number:	Expiry Date:

3. Contact Details *(Complete where relevant. At least one number is required)*

Mobile Number:	Work Number:	Home Number:

Email Address:	Alternate Email Address

SECTION B. COVER DETAILS

(To be completed by the Insurance Agent)

1. Spouse Life to be Insured	Sum Insured (K)	Product Term (Years)	Annual Premium (K)	Instalment Premium (K)
Term Life Rider				
Accidental Death Benefit				
Accidental Total & Permanent Disability				
TOTAL				

SECTION C. GENERAL DETAILS

(To be completed by the Spouse to be Insured)

1. Provide the following details of your current main occupation.

Type (e.g. clerk, police officer, miner, etc.)	Years of Employment	Industry (e.g. mining, banking, etc.)

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

K _____

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

Yes ☐ No ☐ ► *If Yes, please provide details:* _____

SECTION D. MEDICAL DECLARATION

(To be completed by the Spouse 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? Yes☐ No☐ ► *If Yes, please provide details below:*
Height cm	Weight kg	Yes☐	No☐	
Change in Weight		Change in kgs		Reason(s) for change.
Increase ☐	Decrease ☐			

Have you in the last 2 years used or consumed any of the following?

Tobacco Consumption	Narcotics Consumption	Alcohol Consumption	Betel Nut Consumption	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)	(# per day)	(# or 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. 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 of travel.*

4. 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.*

5. 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.*

6. Are you on regular medication or seeing a doctor on a regular basis? Yes☐ No ☐ ► *If Yes, please provide details on type of medication, how long you have been taking this medication and reason for seeing the doctor on regular basis.*

SECTION E. HEALTH DECLARATION

(To be completed by the Spouse to be Insured)

You **MUST** disclose details of any Existing Medical Conditions. Existing Medical Condition means:

(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 diagnosis has been made.

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 of the following conditions?

Place a ✓ under "Yes" or "No" in the space provided to indicate your appropriate answer.	Yes	No
(a) Diabetes or abnormal sugar level.	◯	◯
(b) High blood pressure or hypertension, or any abnormal blood pressure reading including pregnancy induced hypertension.	◯	◯
(c) Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of blood in the urine.	◯	◯
(d) Cancer, tumour, cyst or growth of any type whether it be benign or malignant. Abnormal pap smear for female or any prostate condition for male.	◯	◯
(e) Coronavirus disease specifically caused by the SARS CoV-2 Virus (COVID 19) from any one of its viral strains (including if you are currently in isolation as a result of being identified as a primary or secondary contact of a person who has tested positive for the Coronavirus disease)	◯	◯
(f) Any other major or chronic illness, medical condition, injury, operation, disability or physical abnormality not mentioned above?	◯	◯
(g) Any diagnostic investigation that would have reflected a medical condition or have been prescribed ongoing medications?	◯	◯

If you have answered YES to any of the questions above, please provide full details below and complete the required Supplementary Personal Statement in relation to the medical illness of the condition disclosed:

Initial _____

Please complete questions (h) to (s) if you have answered YES to any of the above questions or:-

- **You are over 40 years of age; or**
- **Sum of all Life Insurance cover whether existing and including this application is > K35,000**

Place a ✔ under "Yes" or "No" in the space provided to indicate your appropriate answer.	Yes	No
(h) Leukemia, haemophilia, anemia or any other form of blood and circulatory disorders	◯	◯
(i) 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.	◯	◯
(j) Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath and any other disorders of the respiratory system, or pleurisy or emphysema.	◯	◯
(k) 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.	◯	◯
(l) 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.	◯	◯
(m) Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat.	◯	◯
(n) Skin disorder (s) of any type for example, dermatitis, eczema, psoriasis, skin lesion or melanoma.	◯	◯
(o) Sexually transmitted infections including syphilis, gonorrhea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies.	◯	◯
(p) Night sweats, inexplicable weight loss, persistent fever, diarrhea or swollen glands.	◯	◯
(q) **Males Only** – Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder and urethra.	◯	◯
(r) **Females Only** – Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems.	◯	◯
(s) **Females Only** – Are you pregnant? If Yes, please provide the expected date of delivery. ____ / ____ / 20____	◯	◯

2. 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)*

SECTION F. THIRD PARTY DECLARATION

(To be completed by a third party completing the form on behalf of the Proposed Policy Owner/Spouse to be Insured)

I certify that:

(a) the Proposed Policy Owner/Spouse 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/Spouse to be Insured and

(c) the information provided in this application form has been read back to the Proposed Policy Owner/Spouse 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:

Initial _____

SECTION G. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

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

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

1. **Declare** the information in this application form is provided in the utmost good faith and is true, correct and complete.
2. **Understand** that this application is subject to BSP Life's acceptance, underwriting requirements, payment of premium and any other requirements. Claims must meet Policy terms and conditions.
3. **Understand** that BSP Life relies on the information I have provided in this application form to communicate with me and pay claims. It is my responsibility to inform BSP Life of any changes to my address (email and postal), preferred communication method and bank account details. BSP Life does not accept any responsibility for any communication, or payments made, to my last nominated address or bank account.
4. **Understand and consent** to, subject to applicable privacy laws and policy:
   (a) BSP Life, its related entities or agents to collect, disclose, use and store our medical and personal information to assess this application form, process future claims and provide services.
   (b) this information being stored, including in electronic form, 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 PNG or elsewhere).
5. Consent to email communication with BSP Life:
   (a) regarding this application form, my Policy including any notices, correspondence or communication, which will be issued electronically unless I request otherwise. I further understand that the 28-day free-look period, within which I can cancel my policy and receive a full refund of premiums paid, commences on the date I receive or have been deemed to receive the policy document in electronic or hard copy, whichever is earlier.
   (b) For all matters concerning my Policy, including instructions sent via email, where permissible by law and subject to BSP Life's requirements.
6. Understand that I am responsible for:
   (a) maintaining proper hardware and software to access and view electronic communication
   (b) ensuring the security of such information
   (c) checking regularly for BSP Life communication
7. Consent to my contact information provided in this application form being disclosed to related entities within, managed or contracted by BSP Life or to entities in the BSP Financial Group for:
   (a) Market research on products and services offered by BSP Life
   (b) Marketing products offered from time to time or
   (c) Customer surveys

*****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 Spouse to be Insured	Signature Proposed Policy Owner	Signature Witness
Name:	Name:	Name:
Address:	Address:	Address:
Signed at:	Signed at:	Signed at:
Date:	Date:	Date:

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

SECTION K. AGENT DECLARATION

(To be completed by the Agent who is writing up the proposed Policy Owner)

- I understand that by certifying the identification details of the proposed Policy Owner (as completed within this form above in various sections), I will be held accountable for any breach of PNG's Anti-Money Laundering and Counter Terrorist Financing Act 2015.
- I declare that all details captured are true and correct and the identification presented to me is current and appears to be valid.

Signature Insurance Agent	Date:

Initial _____