BSP Life

LIFE INSURANCE APPLICATION FORM FOR SPOUSE/WAIVER LIFE TO BE INSURED

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life PNG Limited, Level 2, Moki Business Park, Kumul Avenue, Waigani, National Capital District.
Telephone: (675) 305 6214 Email:servicebsplife@bsp.com.pg
Web: www.bsplife.com.pg

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: _____ **Quote No:** _____ **Life ID Number:** _____

Insurance Advisor: _____ **Advisor No:** _____ **Sales Unit:** _____

This application applies to: ☐ Spouse ☐ Waiver life

SECTION A. SPOUSE/WAIVER LIFE TO BE INSURED'S DETAILS *(To be completed by the Spouse/Waiver Life to be Insured)*

1. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Are you a citizen or resident of PNG? ☐ Yes No ☐ If No, what is your Nationality?	

2. Identification Document Details *(Complete the following for verification of identity. Identification must include date of birth and photograph)*

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

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. Proposed Policy Owner Bank Account Details - Benefit Payments and Premium Refunds (if any) will be paid to this account

Bank Name and Branch:	Bank Account Number:	Bank Account Name:

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

1. Spouse Life to be Insured

Product	Sum Insured (K)	Product Term (Years)	Annual Premium (K)	Instalment Premium (K)
Rider 1				
Rider 2				
Rider 3				
Total Expected Premium				
Additional Premium Amount				
Total Premium to be Paid				

2. Waiver Life to be Insured: *(If different to the Primary Life to be Insured / Spouse Life to be Insured. Please ensure this information is the same as on the Life Insurance Application Form)*

Product	Product Term (Years)	Annual Premium (K)	Instalment Premium (K)
Rider 1			

SECTION C. GENERAL DETAILS *(To be completed by the Spouse / Waiver Life. If Waiver Life, answer 1 and 2 only)*

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

4. 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

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

K _____

6. Is the Insurance being taken to cover a loan? Yes ☐ No ☐ ▶ *If Yes, please provide details:*

7. Have you 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 / Waiver 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? Yes ☐ No ☐
Height cm	Weight kg	Yes ☐	No ☐	▶ *If Yes, please provide details below:*
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	Consumption of Betel Nut	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 for travel.*

4. Have you:

a. Flown or do you intend on flying in an aircraft but not as a fare paying passenger on a commercial flight? ☐ Yes ☐ No

b. 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 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. Are you on any 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 reasons for seeing the doctor on a regular basis.*

SECTION E. HEALTH DECLARATION *(To be completed by the Spouse/Waiver Life)*

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 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?		
	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, or any hereditary or genetically related condition? Yes ☐ No ☐ *If Yes, please provide details below:*

Name of family member	Relationship to you	Medical condition	Age at Diagnosis	Age died

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 details below:*

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

4. 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

5. Have you in the last 2 years smoked tobacco or used any other narcotic substance, consumed betel nut, 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 F. THIRD PARTY DECLARATION

(To be completed by the Insurance Advisor or third party other then the Proposed Policy Owner/Spouse/Waiver Life to be Insured)

1. **I** certify that the Proposed Policy Owner/Spouse/Waiver Life to be Insured were unable to fill in this application form.

2. **I** certify that the information given to **Me** by the Proposed Policy Owner/Spouse/Waiver 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 Proposed Policy Owner/Spouse/ Waiver Life to be Insured and explained to him/her in the language and the Proposed Policy Owner/Spouse/Waiver Life to be insured understands its contents.

English ☐ Pidgin ☐ Motu ☐ Other ☐ *(Please specify language)* _____

Name:		
Address:		
Occupation:		
Signature:	Signed at:	Date:

Vetted and Endorsed by Business Relationship Manager

Signature:	Signed:	Date:

SECTION G. ACKNOWLEDGEMENTS, AUTHORISATIONS, DECLARATIONS AND DISCLAIMERS

(To be completed by the Proposed Policy Owner and Spouse/Waiver Life)

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

I **Declare** that 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 advisors 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 PNG or elsewhere) subject to applicable law and policy.	• I **Consent** to email communication with BSP Life • I **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.

*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 of Primary Life Insured:	Signature Proposed Policy Owner:	Signature Witness:
Name:	Name:	Name:
Address:	Address:	Address:
Signed at:	Signed at:	Signed at:
Date:	Date:	Date: