BSP Life

LIFE INSURANCE APPLICATION FORM

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.

Product: ☐ **Wantok Delite** ☐ **Wantok Sumatin**

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

Insurance Advisor: _____ **Advisor No:** _____ **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. Organisational Details

Full Name:	Authorised Representative and Position:

2. Personal Details

Title:	First Name:	Middle Name(s):	Last Name:

Gender: ☐ Male ☐ Female	Date of Birth:	PNG Citizen living in PNG ☐ PNG Citizen not living in PNG ☐ Non PNG Citizen ☐	Nationality: _____

Have you, your family members or close associates been entrusted with any prominent public function in PNG 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 entity, Department Secretary, 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.*

3. Identification Document Details *(Complete the following for verification of identity. Identification must meet a combined value of 40 points or more)*

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:

All policy communications, including your Policy Document, will be sent to your email if provided. A hard copy can be requested in writing or in person. The 28-day free-look period begins from the date your Policy Document is emailed, posted, or delivered, whichever occurs first.

Email Address:	Alternate Email Address:
Postal Address:	
Physical Address: *(If not the same as the above)*	

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

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 and Branch:	Bank Account Number:	Bank Account Name:

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

Name of Employer (or Company if self-employed):	Employee ID Number:	Years of Employment:

SECTION C. PRIMARY LIFE TO BE INSURED'S DETAILS *(To be completed if the Primary Life to be insured is different from the Proposed Policy Owner)*

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

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

Physical Address:
Province:
Phone Number:

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

1. Primary Life to be Insured	Sum Insured (K)	Product Term (Years)	Annual Premium (K)	Installment Premium (K)
Base Product				
Rider 1				
Rider 2				
Rider 3				
Total Expected Premium				
Additional Premium Amount				
Total Premium to be Paid				

2. Additional Life(Yes) to be Insured: **Spouse** ☐ Yes ☐ No and/or **Waiver Life** ☐ Yes ☐ No

▶ *If Yes, please complete the Spouse/Waiver Life Insurance Application Form.*

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

1. Please fill in the table below:

Measurement				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			
Change in weight				Reason(s) for change	
Increase ☐		Decrease ☐			
Have you in the last 2 years used or consumed any of the following?					
Smoker Status	Narcotics Consumption	Alcohol Consumption	Consumption of Betel Nut	Consumption of non-prescribed drugs / intoxicants	
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	If yes, name drug/intoxicants:	
(# per day) How long?	(# 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 intend to reside in or travel to another country within the next 5 years? ☐ Yes ☐ No

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.*

SECTION F. OCCUPATIONAL DETAILS

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 any other employment, secondary occupation, part-time, freelance, or business activities? ☐ 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

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

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

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

5. 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:*

6. 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 the Primary Life to be Insured for all products)*

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?		
(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 your parents, brothers or sisters died or suffered from diabetes, heart attack, high blood pressure, stroke, heart disease, kidney disease, cystic fibrosis, cancer, mental disorder, or any of your sexual partners suffered or died from tuberculosis, hepatitis, AIDS, or AIDS related conditions?

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? ▶ *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, computerized 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 Condition	Name of Medical Attendant, General Practitioner or Clinic	Postal/Email Address	Reason(s)

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

Salary Deduction: ☐ Fortnightly ☐ Semi - Monthly ☐ Monthly

Name:	Phone:	Email:	Payroll/Staff Number:

Direct Deduction: ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Semi - Annually ☐ Annually

Name:	Phone:	Email:	Payroll/Staff 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 and Branch:	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 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: *

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

SECTION K. ADVISOR DECLARATION

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

I confirm that:

- 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 valid.

Signature:	Date: