MEDICAL INSURANCE PROPOSAL
SINGLE COVER

Suva: 231 Waimanu Rd Phone: 331 1055 Fax: 330 3475 **Nadi**: Main Street Phone: 670 1451 Fax: 6701221

Before any question is answered, please read carefully the declaration at the end of this Proposal, which must be signed and dated. Please ensure that the person to be insured answers all questions fully and correctly. All questions must be fully answered, any questions left unanswered will delay the assessment of this Proposal.

NO INSURANCE IS IN FORCE UNTIL THIS PROPOSAL HAS BEEN ACCEPTED BY OUR UNDERWRITERS AND THE FIRST OR SINGLE PREMIUM PAID TO US OR TO YOUR APPOINTED BROKER.

Section 1: Details of the Primary Life to be Insured

Mr/Mrs/Miss/Ms/Other				**Tax ID No.**	
Previous name (if changed)				**EDP No.**	
Mailing Address					
Home Address					
Date of Birth		**Gender**	☐ **Male** ☐ **Female**		
Occupation		**Height**	**cm**	**Weight**	**kg**
Contact Details	***Phone:***	**Email Address**			
Nationality		**Marital Status**	☐**Married,** ☐**Single,** ☐**Divorced,** ☐**Separated,** ☐**Widowed,** ☐**De-Facto**		

Section 2: Details of the proposer, if different from the person to be Insured

Mr/Mrs/Miss/Ms/Other Employer/Industry in case of Group Insurance			
Previous name (if changed)			
Mailing Address			
Contact Details	***Phone:***	**Email Address**	

Section 3: G.P. details

Name of doctor who currently holds your medical records	
Address and telephone number	
If you have changed doctors within the last 3 months, please give the name, address and telephone numbers of your previous doctor	

Section 4: Smoking and alcohol details (If Yes to any of the following questions, please advise average consumption per day)

Have you or any one in your family smoked or used any form of tobacco product in the last 12 months?	☐**Yes** ☐**No**	
Drink Alcohol?	☐**Yes** ☐**No**	
Drink Kava	☐**Yes** ☐**No**	

Section 5: Insurance Details

Are you currently effecting or intending to effect any other Medical Insurance cover, or have you done so within the last 12 months? If so, please give details of companies, dates and sums Insured – attach a separate sheet if you need to.	
Are you currently effecting or intending to effect any other Medical Insurance cover, or have you done so within the last 12 months? If so, please give details of Insurer and Group Scheme name	

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Section 6: Personal History (If, yes, to any of the following questions, please provide details, including name of doctor, hospital, dates, duration, test results etc.)

Have you or any one in your family consulted any doctor, hospital or clinic within the last 5 years?	☐Yes ☐No	
Are you taking medicine or drugs, whether or not prescribed by a medical practioner, or receiving any treatment?	☐Yes ☐No	
Have you ever suffered from (a) Any chest or lung disorder?	☐Yes ☐No	
(b) Anxiety, depression or other mental or nervous disorder?	☐Yes ☐No	
(c) Arthritis?	☐Yes ☐No	
(d) Epilepsy?	☐Yes ☐No	
(e) Any stomach or bowel complaint?	☐Yes ☐No	
(f) Diabetes, gout, kidney, liver, prostate or bladder problem?	☐Yes ☐No	
(g) Heart disease, rheumatic fever or chest pain?	☐Yes ☐No	
(h) High blood pressure or stroke?	☐Yes ☐No	
(i) Lump, cyst or cancer?	☐Yes ☐No	
(j) Any operation, X-rays or special investigations?	☐Yes ☐No	
Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australia?	☐Yes ☐No	
Within the last 10 years, have you lived for longer than 1 month in any country outside your normal country of residence, Western Europe, North America Australia or New Zealand?	☐Yes ☐No	
Do you engage in hazardous sports, such as aviation, motor sports, diving, etc?	☐Yes ☐No	
Have either of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer or a nervous disorder?	☐Yes ☐No	
Has any application for Insurance on your life been declined, withdrawn by yourself or accepted at special terms?	☐Yes ☐No	
Have you ever tested positive for HIV/AIDS, or are you awaiting the results of such a test?	☐Yes ☐No	
Within the last 5 years have you been exposed to the risk of HIV infection? (Note: this can be caught through unsafe sex, intravenous (IV) drug abuse, blood transfusions or surgery undertaken outside the EU, USA/Canada, Australia or NZ.)	☐Yes ☐No	
Within the last 5 years have you tested positive or been treated for any disease which was transmitted sexually?	☐Yes ☐No	
Have you ever been tested or treated for other sexually transmitted diseases or hepatitis B or C?	☐Yes ☐No	
Are you using or have you ever used drugs other than those prescribed by a doctor or obtained over the counter from a pharmacy? i.e. recreational drugs such as ecstasy, cocaine, heroin, etc.	☐Yes ☐No	

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Nature of business or occupation in which you are engaged (if more than one, please state all)	
Please state rank and duties if a member of the Armed forces.	
Do your duties involve you in any way (other than clerical) with:	**If, yes, to any of the following question, please give full details**
1) the licenced trade of entertainment industry	☐ **Yes** ☐ **No**
2) working at heights, offshore, aviation (other than or scheduled flights), diving, or the fishing or mining industries, work requiring special safety precautions or any other activity which may be regarded as hazardous?	☐ **Yes** ☐ **No**
Does your work require a special licence or permit e.g.diving/driving/handling hazardous chemicals	☐ **Yes** ☐ **No**

Section 7: Beneficiary to Funeral Assistance Benefit

Title	Full Name as per Birth Certificate	Date of Birth	Gender	Relationship to the Insured

SECTION 8: IMPORTANT NOTES

- Please note that your answers to the questions on this form will be used to assess this Proposal. All material facts must be disclosed since part or all of the benefit might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of the Proposal. If you are unsure whether a particular fact is material you should disclose it. You must not assume that we shall be asking your doctor for confirmation of what you have told us.
- Cover will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.
- In most instances your payments will be as originally quoted. Revised terms may be offered to you, but occasionally we may be unable to offer any terms.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- On occasion the faxing of medical reports may help to ensure a quicker assessment of your application. We only accept faxed information direct to a fax machine in a secure part of our building. This ensures that we maintain strict confidentiality. If you do not agree to allow the faxing of information, please indicate by deleting the appropriate section of the Declaration.
- You are entitled to ask for a copy of our standard policy terms and conditions and a copy of your application form at any time.

SECTION 9: ACCESS TO MEDICAL REPORTS

It may be necessary for us to obtain medical reports to support your application. Before we can ask any doctor that you have consulted to complete a report, we need your permission.

- You do not have to give your consent, but if you do not we may be unable to proceed. This does not stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If you do, we shall tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give Capital Insurance Limited access to this information.

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SECTION 10: DECLARATION

Please sign this Declaration once you have read it together with the important Notes. If you are unsure as to whether any information should be given, you should provide it. If you are applying for insurance with other companies at the same time, by signing the Declaration you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we shall ask for your specific written permission before doing so.

- I/We will inform you immediately of any changes that occur before the plan starts. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.
- To the best of my/our knowledge and belief all the statements made, which includes anything I/We may have said, have been recorded accurately in this application or are attached in a sealed Private and Confidential envelope, and are true and complete. This disclosure will form the basis of the contract.

  ☐ Please tick if you have attached a Private and Confidential envelope.
- I/We agree to Capital Insurance Limited obtaining medical information from any doctor whom I/We have consulted about my/our physical or mental health, in order to assess my/our proposal. You may obtain relevant information from other insurers about previous or concurrent applications for life, critical illness, sickness, disability, accident or private medical insurance that I/we have applied for. I/We authorize those asked for such information to provide it on the production of a copy of this consent. This consent allows Capital Insurance Limited to obtain medical reports at any time during the life of the cover or after my death to support any claim made on the cover proceeds.
- I/We agree that a copy of the agreement given in this declaration will have the validity of the original.
- I/We agree to Capital Insurance Limited accepting medical reports faxed directly to the company from my doctor's surgery. I/We also do not* object to copies of the report being faxed to any other company that I have applied to at their request. (*Delete the word "not" if you do not wish us to fax information.)

By signing this declaration, I am/we are allowing Capital Insurance Limited to process my/our application using the information that I/we have provided. This information can also be used to process any claim made on this policy.

I/We have read the Declaration, Important Notes and information relating to my/our rights.

Full Name of Applicant:	**Signed at**	**Date**
Signature:		
Full Name of Witness:	**Signed at**	**Date**
Signature:		