



Please state the exact nature of your work


**PERSONAL STATEMENT** (to be completed by the Life to be Insured)

We understand that the medical questions we ask in this section may be sensitive, but it is very important that you give us all the information that may affect your application for insurance.

If you answer YES to any of the questions below please provide the details in the space provided. Please give as much detail as possible including details of any medical condition, treatment, dates and results.

**PART A**

1. Give details of any Colonial Life or Health policies in force or other policies in force or proposals being made to other companies	Office	Policy No.	Life Sum Insured	Accident Sum Insured
2. Your Doctor's Details	Name			
	Mailing address			
3. Have you ever taken a Colonial Medical Examination?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		
	Name of Doctor		Date of Examination	/ /
4. When did you last consult a doctor?	Name		Date Consulted	/ /
	Reason			
	Treatment Received			
5 (a) What is your height and weight?	Height	cm/feet & inches	Weight	kgs/lbs
(b) Has your weight altered in the last 12 months?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Please give reason(s)	
	Increase	kgs/lbs	Decrease	kgs/lbs
<b>(Occasionally and Socially not acceptable. Be precise)</b>				
6. (a) Do you take alcohol?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Please give details	Type <input type="text"/> Daily Quantity <input type="text"/>
(b) Do you take kava?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Please give details	Daily Quantity <input type="text"/>
(c) Do you smoke?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Please give details	Type <input type="text"/> Daily Quantity <input type="text"/>
(d) If yes, what age did you start smoking?	<input type="text"/> Age			
(e) If no to (c), have you ever smoked?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	▶ Please give details	Date Ceased <input type="text"/> / <input type="text"/> / <input type="text"/> Reason <input type="text"/>
7. If you answer YES to any of the questions (a – c) below, please complete schedule at below				
(a) Have you ever had any physical impairment or sickness (other than mild ailments such as colds or flu)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		
(b) Have you ever taken any medication or sought medical advice or even been hospitalized?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		
(c) Have you ever had any sexually transmitted infections, or are you suffering from AIDS or AIDS related conditions and antibodies?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		

**SCHEDULE FOR QUESTION 7**

Date	Name and Address of Doctor, Hospital, etc	List physical disability, impairment, sickness or medication taken

8. (a) Have any of your parents, brothers or sisters died or suffered from heart disease including cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy, tuberculosis or hepatitis No  Yes  ► Please give details
- (b) Has a partner or spouse suffered from tuberculosis, hepatitis, AIDS or AIDS related conditions and antibodies? No  Yes  ► Please give details

Family Member/Spouse or Partners	Condition	State of Health	Age at Diagnosis	Age at Death

**FOR FEMALES ONLY**

9. i. Are you pregnant? No  Yes  ► Please give details Expected Delivery Date  /  /
- ii. Have you had any Pap Smear? No  Yes  ► Please give details Date of Test  /  /  Results
- iii. Mammograms No  Yes  ► Please give details Date of Test  /  /  Results
- iv. Are you suffering from any medical condition induced by this pregnancy? No  Yes  ► Please give details Condition being suffered due to pregnancy

**INSURANCE SALES AGENT/THIRD PARTY DECLARATION**

**IMPORTANT NOTICE**

This declaration must be completed if this application form has been filled in by a Colonial Sales Agent or, any other party other than the Life To Be Insured/Policy Owner.

- I (Registered name in full)  of  residential address, occupation  certify that the Life to be Insured/ Policy Owner was unable to fill in this application form and has authorised me to fill out this application on the Life to be Insured/Policy Owner's behalf.
- I certify that the information given to me by the Life To Be Insured/Policy Owner has been accurately and honestly recorded by me in this application form.
- I certify that the information filled out in this application form has been read back to the Life To Be Insured/Policy Owner and explained to him/her in the English/Fijian/Hindi/Chinese/Other language and the Life to be Insured/Policy Owner understood its contents thereof.

Full name and Signature of Colonial Insurance Sales Agent /Third Party

Name in full:	Date
Signature: <span style="float: right;">Signed at:</span>	/ /

Full name and Signature of Witness

Name in full:	Date
Signature: <span style="float: right;">Signed at:</span>	/ /

**DECLARATION AND CONSENT**

**IMPORTANT NOTICE**

Your duty of Disclosure

Before you enter into this contract of Insurance ("Insurance") you have a duty to disclose to Colonial Fiji Life Limited ("Colonial") every matter that you know or could reasonably be expected to know which is relevant to its decision whether to accept the risk of the Insurance and if so on what terms.

You have the same duty to disclose those matters to Colonial before you apply to vary or reinstate the Insurance. If you fail to comply with your duty of disclosure to Colonial and it would not have insured the insurance on the same terms if disclosure had been made, Colonial may cancel and void the insurance from inception.

The below named Life to be Insured and Policy Owner declare and agree that

- Tick only one of a or b
  - The above answers have been entered by me/us and have been checked by me/us.

Or

  - The Sales Agent has fully explained the contents and questions of this application to me and that he has recorded the replies as per my dictation. I further declare that I have signed the proposal form only after ensuring that I have understood its contents and the replies have been correctly recorded therein.

2. I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this Application are true and complete to the best of my/our knowledge.
3. Should the Life to be insured undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the Insurance, I/We agree to notify Colonial immediately as this information is relevant to any decision Colonial may make to accept this Application.
4. I/We understand that the information in this Application including any statements made by any medical examiner on my/our behalf will form the basis of an insurance contract between me/us and Colonial.
5. I/We understand the Insurance proposed in this Application WILL NOT COMMENCE until this Application has been accepted by Colonial and the initial premium has been received by Colonial and policy issued.
6. I/We will be bound by the standard conditions applicable to the proposed Insurance upon Colonial's acceptance of this Application.
7. I/We:
  - agree that the information contained in this Application be disclosed to other entities within, or managed by the Colonial Group\* for the purpose of marketing to me/us products offered from time to time by the Colonial Group and authorise those other entities to seek access to that information.
  - OR
  - do not agree that the information contained in this Application be disclosed to other entities within, or managed by, the Colonial Group
8. I/We acknowledge that all material health information has been disclosed in this application, including any pre-existing conditions.
9. I/We understand that this Application does not cover any benefit payable in the event of death or disability occurring from war or war service, however defined and including war against terrorism whether war be declared or not, or warlike operation, or civil or political commotion or civil or political unrest or terrorist attack.
10. I/We authorise Colonial to seek further information as required to assess this application from:
  - Registered Medical Practitioner and Specialists
  - Dentists
  - Counsellors, psychologists and therapists
  - Insurers (whether public or private)
  - Hospitals (whether public or private)

I/We agree that a photocopy of this authority will be valid as an original.

Full name and Signature of Policy Owner or Left/Right Thumb Print

Name in full:	Date
Signature: _____	/ /
Signed at: _____	

Full name and Signature of Witness

Name in full:	Date
Signature: _____	/ /
Signed at: _____	

Full name and Signature of Life to be Insured or Left/Right Thumb Print

Name in full:	Date
Signature: _____	/ /
Signed at: _____	

Full name and Signature of Witness

Name in full:	Date
Signature: _____	/ /
Signed at: _____	

## NOMINATION OF BENEFICIARY (only applies if the Policy Owner and Life to be Insured are the same person)

(NOTE: If the Beneficiary is under 21 years old a Trustee Nomination Form must also be completed).

In accordance with Section 152 of the Fiji Insurance Act, 1998, I hereby nominate the following person/people as beneficiary(ies) in the event of my death.

Name	Age	Relationship	Father's Name	%

Full name and Signature of Policy Owner	Name in full:	Signed at:	Date
	Signature:		/ /

Full name and Signature of Witness	Name in full:	Signed at:	Date
	Signature:		/ /

### Definition

**Vanishing Premium:** An option which can be selected at any stage during the premium paying period. However, the feature can only be effected at a point in time when sufficient bonus has accrued such that its cash value is sufficient to offset all future premiums payable.

**Extended Term Insurance:** The cash value (net of all debts) is used to purchase a paid up term insurance, with the same sum insured as the original basic plan at the attained age of the insured at the time the option was availed of. The option changes the cover to a paid up term insurance cover.

