

# MEDICAL INSURANCE APPLICATION FORM



Please complete the relevant areas of the form, check all details and return it to:  
 Colonial Health Care, 3 Central Street, Private Mail Bag, Suva, Fiji Islands.  
 Telephone: **132 888** or (679) **3214 444** Facsimile: (679) **3300 318**  
 Website: **www.colonial.com.fj**

## PRIMARY APPLICANT

**Your Details** (Please complete all details in **BLOCK LETTERS**)

*\* Please note that Birth Certificates and coloured passport size photographs must be attached for all applicants.*

Title  Given Names  Surname

Date of Birth  /  /  Gender  M  F Marital Status

Home Address

Postal Address (If different from Home Address)

Telephone: Home  Work  Mobile  Facsimile No.  Email Address

If joining under a Group Scheme, please include the following details:

Name of Employer or Group Scheme  Position/Occupation

EDP/FNPF/PAY Number  Date appointed to position

## DEPENDANTS TO BE COVERED

(If more space is required please attach a separate list)

FIRST NAME(S)	SURNAME	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	GENDER (M/F)

*Note - All dependants must be totally reliant on and related to the Primary Insured by being the spouse or partner or biological or adopted single child under the age of 18 years or under the age of 25 years if on full time studies in an accredited recognised educational institution. Proof of being a dependant may be required.*

## CHOICE OF COVER

(Please tick (✓) the level of cover you require)

**Base Plan:**  Priority Hospital Care Plus  Priority Hospital Care  Value Health

**Optional Attachable Benefits:**  Dental & Optical Care  Allied Health Services  Priority Outpatient Care

*(Tick one only)*

Name of nominated Doctor/Clinic:

*Note: Your nominated Doctor/Clinic must be a member of Colonial's preferred provider network. For more information talk to your authorised Colonial Sales Representative or call Colonial EasyCall on 132 888.*

## HEALTH INSURANCE HISTORY

1. Have you had any medical insurance prior to joining Colonial Health Care?  Yes  No

1a) If YES please state the following:

Insurer  Date of Expiry  /  /  Type of Cover

1b) Have you or any listed dependants made a health insurance claim within the last 12 months?  
 No  Yes ▶ If YES, please list details on a separate sheet and attach to your application.

2. Have you, your spouse/partner or any listed dependant ever had any medical, hospitalisation, accident or life insurance application rejected or policy cancelled, rated or restricted?  
 No  Yes ▶ If YES, please list details on a separate sheet and attach to your application.

**PRE-EXISTING CONDITIONS**

A pre-existing condition is an ailment, illness or condition where signs or symptoms have been in evidence which includes but is not limited to any health condition that occurs or exists at any time and that relates to a symptom or circumstance of which the Primary Applicant, spouse/partner or child was aware of, or ought reasonably to have been aware of at the commencement date of the policy. It also includes medical treatment received or sought, prior to the policy commencement date or the date at which cover for an existing policy is upgraded. For more information contact Colonial Health Care on 132 888 or ask your authorised Colonial Sales Representative.

Do you, your spouse/partner or any of your children have any signs or symptoms of any illness, medical condition, ailment or disability?

No  Yes ▶ Give complete details, including date(s) of treatment, surgical procedure, disability and name of consulting doctor where applicable. If you need more space please attach on a separate sheet:

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**PAYMENT DETAILS** (Please tick (✓) your preferred payment option. Premiums are payable in advance)

If choosing Salary Deduction please complete **Salary Deduction Authority Form**. Please note payments other than on an annual basis may attract a Payment Frequency Loading.

**DIRECT**

(Please make cheque payable to Colonial Health Care (Fiji) Ltd.)

- Annual (For a 12 month period)
- Half-yearly (For a 6 month period)
- Quarterly (For a 3 month period)

**GROUP SCHEMES**

(Please make cheque payable to Colonial Health Care (Fiji) Ltd.)

- Annual (For a 12 month period)
- Half-yearly (For a 6 month period)
- Quarterly (For a 3 month period)
- Monthly
- Fortnightly
- Weekly

Premium: \$

Instalment: \$

Receipt No.:

Policy Document to be:  Hand delivered  Posted  Collected

**NOMINATION**

\* Please nominate a beneficiary for the Loyalty Benefit.

**BENEFICIARY**

**RELATIONSHIP TO PRIMARY APPLICANT**

**AGE**

**DECLARATION** (to be completed by Primary Insured only)

I declare that the information provided on this form is true, correct and complete and I will notify Colonial Health Care (Fiji) Limited of any changes.

I declare that all nominated dependants aged between 18-24 covered by this policy are undertaking full time study in an accredited educational institution.

I agree to Colonial Health Care (Fiji) Limited's terms and conditions of policy, which may change from time to time.

I understand that premium rates may increase or benefit entitlements may change from time to time.

I understand that if I or any nominated dependant is joining Colonial Health Care (Fiji) Limited or upgrading cover:

- Waiting periods may apply (depending on the level of cover)
- Proof of identity including the age of my dependants and myself may be required.
- The date of birth of the primary insured and dependants is used to calculate the premium but if the given birth date is found to be incorrect, then Colonial Health Care (Fiji) Limited may retrospectively readjust the premium.
- Colonial Health Care (Fiji) Limited may decide not to accept my application.

I understand that for Priority Hospital Care Plus and Priority Hospital Care, any pre-existing conditions of any listed applicants and dependants, whether declared or not, will not be covered for the first 24 consecutive months of this policy. Pre-existing condition is not covered under Value Health.

I understand that I have a duty to disclose to Colonial Health Care (Fiji) Limited every matter that I could reasonably be expected to know which is relevant to Colonial Health Care (Fiji) Limited's decision to accept the risk.

I understand that failure to disclose (non-disclosure) the required information may make the contract void and if such non-disclosure is fraudulent, Colonial Health Care (Fiji) Limited may take legal action.

I authorise my previous health insurer, hospital, medical or other authorities to release to Colonial Health Care (Fiji) Limited all information required to confirm my benefit entitlements. This authority replaces all previous authorities and remains valid until written notification is given by me to Colonial Health Care (Fiji) Limited.

**Signature of Primary Applicant**

X	Date / /
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**Agent/Broker Name and Number**

Thank you for your application to join Colonial Health Care. Upon acceptance of your application, please allow for up to 5 working days for confirmation of cover.

**FOR OFFICE USE ONLY**

Group Name (If applicable)	Start Date: / /
Policy Header Number	
Renewal date	
Underwriting	