



**MEDICARE APPLICATION
HOSPITALISATION
OUTPATIENT
OPTICAL
DENTAL**



“better health for Fiji”

FijiCare Insurance Ltd
Level 9 FNPF Place
343-359 Victoria Parade
P.O.Box 15808, Suva, Fiji Islands.
Phone: (679) 3302717 Fax: (679) 3302119

Western Branch: Level 1, Shop 5
Airport Central Bldg, Namaka.
P.O.Box 4179, Nadi, Fiji Islands.
Phone: (679) 6727348 Fax: (679) 6727326

FijiCare Insurance Ltd

Application Form



Your duty of Disclosure

It is very important that the answers on your application are true, correct and complete. Claims can be reduced or refused, if it is later found that wrong information has been given.

FNPF #: Employer: EDP #:

Residential Address: Telephone:

Postal Address:

Date Of Birth: Martial Status: Sex:

Height: Weight: Smoker: Yes No

Applicant Name (s)	Sex	Ht	Wt	DOB
<input type="text"/>				

Dependent Name (s)	Sex	Ht	Wt	DOB
<input type="text"/>				
<input type="text"/>				
<input type="text"/>				

PERSONAL STATEMENT

To the best of your knowledge have you, or any of your listed dependents: YES/NO

1. ever had treatment or been informed that you have blood pressure problems, heart trouble, cancer, diabetes, kidney or liver or bowel disease, digestive disorder, lung disease, stroke, fits mental illness or nervous disorder, suffered serious personal injury or AIDS?
2. Ever consulted a doctor for medical or surgical advice or treatment of any ailment, injury or sickness.
3. Ever had an application for life and or Dread Disease Insurance declined or deferred by a life or general insurance company or society or accepted with a loading or otherwise as submitted or received a disability benefit?
4. Ever engaged or intend to engage in any hazardous occupation, sport or other pursuit, or intent to engage in aviation other than as a fare-paying passenger in a commercial airline?

It is important that you answer all questions to the best of your knowledge and belief and disclose all relevant facts. These are facts that an insurer would regard as likely to influence the assessment and acceptance of an application. If you fail, to do so and a policy is issued, all or part of the benefit may not be available. If you in any doubts as to whether certain facts are relevant, you should disclose them.

Details of "YES" answers to the above questions:

(Don't forget the name and address of the treating doctor for any conditions you have mentioned.)

I/ We, the life to be insured, declare that;

1. I/ We hereby apply for membership to FijiCare and certify that the declaration listing dependent is true & correct.
2. The answers given above and/or to the Medical Examiner for FijiCare Insurance Ltd are true.
3. Any Medical Practitioner who has or may be consulted by me r any of my dependents is authorized to divulge at any time to FijiCare Insurance Ltd any information with regard to myself & them.
4. I/We waive all professional confidence and provisions of the law relating to privilege forbidding disclosure material to the insurance cover.
5. Any untrue statements I/We may have made, or material information I/We may have withheld may result in the contract being declared void.
6. the company will be free from all liability until the proposal has been accepted and the policy issued
7. all notices shall be sent to FijiCare Insurance Ltd, P.O.Box 15808, Suva, Fiji

Signature of Applicant: _____

Date: _____

Witness: _____

Date: _____