Capital INSURANCE GROUP
THE PACIFIC'S INSURER

Term Life Assurance Proposal

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. Any question left unanswered or only answered with a dash will delay the assessment of this Proposal for assurance.

Section 1: Details of Person To be Assured

First Name ..... Last Name ..... Sex: M ☐ F ☐

Address ..... City ..... Province .....

Date of birth ..... (dd/mm/yyyy) Country of Birth .....

E-mail ..... Tel. (Home) ..... Tel. (Bus.) .....

Occupation ..... Company Name .....

Spouse Information (Complete only if applying for Spouse coverage)

Last Name ..... First Name ..... Sex: M ☐ F ☐

Date of birth ..... (dd/mm/yyyy) Country of Birth .....

E-mail ..... Tel. (Home) ..... Tel. (Bus.) .....

Occupation ..... Company Name .....

Other Insurance Do you (Member or Spouse) Have any pending or existing Life or Critical Illness, and/or disability insurance coverage with Capital Life or any other company? **yes** ☐ **no** ☐

If Yes, please complete the following:

Name of Applicant	Company Name	Personal or Business	Type of Insurance	Amount	Do you intend to replace this coverage?
				K	yes ☐ no ☐
				K	yes ☐ no ☐

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

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Section 2: Policy Details

I am applying for: ☐ New Coverage ☐ Additional Coverage

If currently insured under any of the following plans, list policy No.....

If applying for additional coverage, DO NOT INCLUDE COVERAGE ALREADY IN FORCE.

Member: ☐ Smoker ☐ Non-Smoker **Spouse:** ☐ Smoker ☐ Non-Smoker

Non-smoker is someone who has not used tobacco or marijuana in any form, including smoking cessation products, in the last 12 months and who meets Capital life's health standards.

TERM LIFE INSURANCE (Coverage in force and applied for may not be less than K50,000 or exceed K1,500,000)

MEMBER	SPOUSE
Amount of coverage applied for	Amount of coverage applied for
K.....	K.....

Section 3: Beneficiary Designation

Beneficiary of Member Coverage

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the estate.

Name	Sex (M or F)	Date of Birth (dd/mm/yyyy)	Beneficiary %
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee

First Name ..... Last Name .....

Relationship to the Beneficiary .....

Beneficiary of Spouse Coverage

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Name	Sex (M or F)	Date of Birth (dd/mm/yyyy)	Beneficiary %
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee

First Name ..... Last Name .....

Relationship to the Beneficiary .....

Section 4: Health Declaration

Both pages must be completed even if all questions are answered no

Member Health Declaration

Member's Physician (Name) ..... Telephone .....

Physician's Address .....

Reason Last Consulted ..... Date Last Consulted .....

Tests, Treatment, Medication Prescribed (if none, state "None") .....

Member's Height ..... cm Member's Weight ..... kg

Has your weight changed in the past year? YES ☐ NO ☐ Gained ..... kg Lost ..... kg

Reason for weight change .....

Spouse's Health Declaration

Spouse's Physician (Name) ..... Telephone .....

Physician's Address .....

Reason Last Consulted ..... Date Last Consulted .....

Tests, Treatment, Medication Prescribed (if none, state "None") .....

Spouse's Height ..... cm Spouse's Weight ..... kg

Has Spouse's weight changed in the past year? ☐ YES ☐ NO Gained ..... kg Lost ..... kg

Reason for weight change: .....

Section 5: NON-MEDICAL INFORMATION

Have you / Has any individual proposed for coverage (Member, Spouse or child(ren)):

1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason:

.....

2. Any intention of piloting an aircraft or participating in scuba-diving, parachuting, hang-gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s).

.....

3. Within the next 12 months, an expectation to travel outside of Papua New Guinea, Australia, New Zealand and/or the South Pacific?

.....

4. Within the next 12 months, an expectation to change country residence? If yes provide details including where you intend to move, when you are moving, why you are moving, and if your occupation is changing.

.....

5. Within the past 5 years, used drugs for other than medical purposes, used marijuana have been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug or alcohol type(s) and date(s) last use

.....

Section 6: Medical Informtaion – Member

Have you ever had any indication of or been treated for conditions involving the following?

	yes	no	comment
1. Your mental health, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?			
2. Your brain or nervous system such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?			
3. Your heart or blood vessels, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischaemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?			
4. Your nose, throat or lungs, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnoea, tuberculosis, or other?			
5. Your abdominal organs, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?			
6. Your kidneys, bladder or reproductive organs, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?			
7. Your blood or glands, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, bleeding tendency, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?			
8. Your breast, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?			
9. Your skin, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, color or have bled, psoriasis, dermatitis, nevus or nevi, or other?			
10. Your eyes or ears, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?			
11. Your immune system, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?			
12. Your muscles, bones, or joints, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?			
13. Cancer, cysts, lumps, polyps, or tumor?			
14. Other illness or disorder not mentioned above, or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?			
15. *Females only:* Are you currently pregnant? If yes, give due date and the name and address of your obstetrician/gynecologist: a) What was your pre-pregnancy weight? .....kg b) Have there been any complications with your pregnancy?			
16. Within the past 2 years, have you: a. Had an abnormal mammogram, PSA or any other test or investigation? b. Consulted a specialist, been prescribed medication, other ailments (colds, flu, etc.)? c. Been advised to undergo further investigation, seen another doctor or had surgery? d. Or are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness			

If you answered yes to any of the Questions 1 to 16 above, please give details on the last column.
If additional space is needed, use a separate sheet, signed and dated.

Section 6: Medical Information - Spouse (if applicable)

Have you ever had any indication of or been treated for conditions involving the following?

	yes	no	comment
1. Your mental health, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?			
2. Your brain or nervous system such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?			
3. Your heart or blood vessels, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischaemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?			
4. Your nose, throat or lungs, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnoea, tuberculosis, or other?			
5. Your abdominal organs, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?			
6. Your kidneys, bladder or reproductive organs, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?			
7. Your blood or glands, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, bleeding tendency, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?			
8. Your breast, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?			
9. Your skin, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, color or have bled, psoriasis, dermatitis, nevus or nevi, or other?			
10. Your eyes or ears, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?			
11. Your immune system, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?			
12. Your muscles, bones, or joints, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?			
13. Cancer, cysts, lumps, polyps, or tumor?			
14. Other illness or disorder not mentioned above, or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?			
15. *Females only:* Are you currently pregnant? If yes, give due date and the name and address of your obstetrician/gynecologist: a) What was your pre-pregnancy weight? .....kg b) Have there been any complications with your pregnancy?			
16. Within the past 2 years, have you: a. Had an abnormal mammogram, PSA or any other test or investigation? b. Consulted a specialist, been prescribed medication, other ailments (colds, flu, etc.)? c. Been advised to undergo further investigation, seen another doctor or had surgery? d. Or are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness			

If you answered yes to any of the Questions 1 to 16 above, please give details on the last column.
If additional space is needed, use a separate sheet, signed and dated.

Family Medical History

17. a) have any of your parents or sibling (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?

.....

b) Have any of your parents or siblings ever been diagnosed with Huntington Chorea, polycystic kidney disease or other disease (excluding kidney stones), Parkinson's disease, multiple Sclerosis, Alzheimer's disease, amyotrophic lateral Sclerosis (also called as ALS or Lou Gehrig's Disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa or any hereditary disease?

.....

If yes to a) or b) above, please complete the following

Name of Applicant	Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause (if applicable)

The Insurer may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV), which will be made at no expense to the Member. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

Section 7: Financial Information

MEMBER	SPOUSE
What is your annual earned income (after expense and before taxes)?	What is your annual earned income (after expense and before taxes)?
K.....	K.....

Declaration & Authorization *(Please read carefully before signing)*

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.
- If we ask you to attend a medical examination, it will be necessary for us to share the application information with another company authorized by us. They will make the arrangements for the examination to take place.
- It may be necessary to send your application and relevant medical reports to our Reassurers for their opinion or agreement of the terms offered if they are to participate in cover.
- On occasion the email of medical reports may help to ensure a speedier assessment of your application. We only accept emailed information direct to our Underwriting email address. This ensures that we maintain strict confidentiality. If you do not agree to allow the emailing of information, please indicate by deleting the appropriate section of declaration.

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. Although there are no legal provisions in PNG, we follow best – UK legislation. None in PNG practice and undertake the following:
- 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.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.
- If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he/she feels that it would cause physical or mental harm to you or others.
- 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.
- I/We do not* wish to see the report before it is sent to Capital Life Insurance Limited. (*Only delete the word "not" if you wish to see the report before it is sent).

Section 10: DECLARATION - MEMBER

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 Life 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 Life 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.
- This information can also be used to maintain management information for business analysis.
- We agree that a copy of the agreement given in this declaration will have the validity of the original.
- I/We agree to Capital Life Insurance Group accepting medical reports emailed directly to the company from my doctor's surgery. I/We also do not* object to copies of the report being emailed to another company that I have applied at their request (*Delete the word "not" if you do not wish us to email information.)

By signing this declaration, I am/we are allowing Capital Life 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.

Member's Signature..... Signed at (City/ Town) ..... Date.....

Spouse's Signature ..... Signed at (City/ Town) ..... Date.....

EMPLOYER ACKNOWLEDGEMENT (HR/AUTHORISED ADMINISTRATOR)

Name ..... Position ..... Date .....

FOR OFFICE USE ONLY: UNDERWRITING COMMENTS

Date processed.....
(dd/mm/yyyy)