MICRO INSURANCE APPLICATION FORM

Reference ID No.:_____ Department: _____
(Social Welfare Reference ID/ EDP No. /TIN)

SECTION A: INSURED PERSON *(Please fill all applicable information below)*

Registered Member: Mr / Mrs / Ms *(Please circle)*

Given Name(s): _____Surname: _____

Date of Birth: _____Age:_____ Gender: M / F *(Please circle)* Marital Status:

Residential Address: _____

Postal Address (if any): _____

Email: _____Phone No: _____

Any pre-existing medical condition? _____

SECTION B: NOMINATION OF BENEFICIARY

I nominate _____(company name) to act on my behalf to pay the persons listed below to whom the sum insured from the insurance will be paid in the event of my death.
The benefit will be payable to the first beneficiary. If my first beneficiary is unavailable at the time of death, then the benefit will be payable to the second beneficiary. In case, either of these beneficiaries are not available at the time of death, the benefit will be payable to my third beneficiary.

Nomination of Beneficiary (Name)		Relationship to Application	DOB	Phone
1				
2				
3				

I, the life to be insured, declare that all information on this application form is true and correct.

Signature of Insured Person: _____ Date: _____

Witness Name: _____

Witness Signature & Stamp: _____ Date: _____

(IMPORTANT: *This form is to be witnessed by authorized persons only i.e. Justice of the Peace, Commissioners of Oaths, Barristers and Solicitors, Social Welfare Officers and Head of Human Resources/Finance Departments)*

"better health for Fiji"

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