Appendix B

PSC SERVICE COMMISSION (PSC)
APPLICATION FOR MEDICAL INSURANCE

1. *Member Details*:

MEMBER'S FORENAMES (MR/MRS/MS): ____

MEMBER'S SURNAME: ___________________________ **DATE OF BIRTH:** _________________

EDP / FNPF NO: ___________________ **MINISTRY / DEPT:** ________________________________

MAILING ADDRESS: ____

DATE JOINED THE SERVICE: _____________________ **PHONE NO:**_______________________

DO YOU HOLD A VALID PASSPORT?: ☐ **YES** ☐ **NO**

Please advise us of any change of details.

Dependent Persons Name	Date of Birth	Relationship to Member	Do they hold a Passport?

2. *Coverage Options:*

Insured Persons:
- **Individual Membership:** ☐
- **Family Membership:** ☐

Plan Options:
- **Pacmed / Medivac:** ☐
- **Medivac:** ☐
- **Executive:** ☐
- **Outpatient Care:** ☐
- **Dental / Optical / Maternity:** ☐
- **Gold Cover / Suva Private Hosp:** ☐
- **Funeral Benefit :** ☐

3. *Pre-Existing Conditions:*

NOTE: Pre-existing conditions are excluded unless we have agreed to their inclusion.

Name	Age	Occupation	Details of Pre-Existing Conditions

Your Duty of Disclosure	Your duty, however, does note require disclosure of matter.	Non-Disclosure
Before you enter into a contract of general insurance with an Insurer, you have a duty of disclose to the Insurer every matter that you know is relevant to the Insurer's decision whether to accept the r isk of insurance and, if so, on what terms. You have the same duty to disclose those matters, to the Insurer before you renew, extend, vary or reinstate a contract of general insurance.	- That diminishes the risk to be undertaken by the Insurer. - That is of common knowledge. - That your Insurer knows of, in the ordinary course of its business, ought to know, as to which compliance with your duty is waived by the Insurer.	If you fail to comply with your duty of disclosure, the Insurer may be entitled to reduce its liability under the contract in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, the Insurer may also have the opinion of avoiding the contract from its beginning.

Date: ___________________________________ Signature: ________________________________

4. Premium Details:

		PREMIUM	
No	**Plan Options**	**Fortnightly**	**Weekly**
1.	**Pacmed / Medivac**	**$**	**$**
2.	**Medivac**	**$**	**$**
3.	**Executive Cover**	**$**	**$**
4.	**Outpatient**	**$**	**$**
5.	**Dental / Optical / Maternity**	**$**	**$**
6.	**Gold Cover / Suva Private Hospital**	**$**	**$**

5. Authority to Deduct Payment from Wages / Salary:

To ____

I ____ Occupation: ______________________________

in the _______________________________ EDP / FNPF No: _________________ hereby request you as my agent to deduct payments from my salary / wages for my Medical Programme of __________

_________________________dollars and ____________________________cents ($______________).

Please remit this payment to DOMINION INSURANCE LIMITED until such time as the PUBLIC SERVICE COMMISSION GROUP INSURANCE decides to terminate the policy or until I request this deductible to be cancelled in writing (whichever is first). All payments on my behalf pursuant to this request shall be deemed to be a payment made by me personally.

Signature: _______________________________ Date: _____________________________