

Confidential Fact-Finding form for Individuals Health Insurance

Individual Client

Insured name:

Insured Address:

Postal Code:

Email address:

Telephone number:

Fax number:

Beneficial Owner (Person In Charge / PIC)

Name:

Address:

Postal Code:

Email address:

Telephone number:

Fax number:

Private Data

Place of birth:

Date of birth (dd/mm/yyyy): / /

Nationality:

Identification KTP / SIM / PASSPORT NO.:

KIMS / KITAS / KITAP NO.:

Tax Registered number: (if any)

Occupation:

Company Name:

Company Address:

Telephone number:

Fax number:

Type of Business:

Working Experience: / Years / Months

Annual Income: up to Rp. 30 million Rp. 30 - 100 million Rp. 100 - 300 million more than Rp. 300 million

Source of Income: salary Others:

Bank Account Name of Bank:

Account No.:

Policy coverage Fire Engineering Motor Marine Others:

Supporting Documents

Copy of KTP/SIM/Passport

Copy Tax Register - NPWP (if any)

Reference (fill by Insurer)

Client Code

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Intermediary Code

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Signature:

Date (dd/mm/yyyy):

/ /

This Application Form should be completed in compliance with Law Number 15/2002, Minister of Finance of The Republic Indonesia Decree Number 45/KMK 06/2003 regarding Implementation of Know Your Customer (KYC) Principle for Non Bank Financial Institution

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