

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):

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This Application Form should be completed in complied 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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