"Know Your Client" Form
Confidential Fact Find for Individual Health Business
For

_____
(Client)

By

_____
(Insurance Advisor)

Important Notice to Clients
For General Agents/Banks Your insurance advisor is a representative of (name of company) and can advise you on the products of 1. Insurer: 2. Insurer: 3. Insurer: **For Insurance Brokers/Financial Advisers/Banks** Your insurance advisory is a broker with _____(name of company) As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he sources the products. **<u>Standard statement applicable to all advisors</u>** Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given. A policy purchased without the proper completion of a "Know Your Client" form may not be appropriate to your needs.

Application type
Client's choice (Please tick boxes [√] where appropriate) 1. ☐ I/We wish to disclose all information requested for in this Form (Please complete and sign "Know Your Client" and "Our Advice and Reasons Why" forms) 2. ☐ I/We wish to receive product advice only (Please sign below and upon completion of Section 2 – "Our Advice and Reasons Why", sign Section 3 - Acknowledgement) 3. ☐ I/We do not wish to receive any advice from my/our advisor. (Please sign below) I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.
Signature of client (on behalf of all applicants): Date:
Signature of Advisor : Date:

Personal Information							
Name: Mr/Mrs/Miss/Ms				**Nationality:**			
NRIC/ Passport No.:	\	**Date of birth:**	__/___/__ (dd/mm/ yyyy)	**Marital Status:**	Single/Married/ Divorced/ Separated/ Widowed	**Gender:**	M/F
Email address:				**Telephone number:**			

Employment details (Please tick boxes [√] where appropriate)					
Current occupation:		**Monthly income range:**	☐ Below $2,500	☐ $2,500 to $5,000	☐ $5,001 & above

Details of Spouse & Dependants (If family coverage is required)						
Name/ Relationship	**DOB** (dd/mm/yyyy)	**Gender**	**Occupation**	**Monthly Income Range**(Please tick boxes [√] where appropriate)		
Spouse	/ /	M/F		☐ Below $2500	☐ $2500 to $5000	☐ $2500 to $5000
Child	/ /	M/F				
Child	/ /	M/F				
Child	/ /	M/F				
Child	/ /	M/F				

Existing Health Insurance policies				
This covers all Health Insurance Polices you currently have (e.g. CPF-approved Medical Scheme, Personal Medical, Hospital Income, Long Term Care, Employer Sponsored Scheme etc).				
Policy Type*	Insured**	Type & Amount of Benefit++	Annual Premium++	Expiry Date++
* Individual or Group policy from employer				
** Y = You; S = Spouse; J = Joint				
++ Please provide benefit schedule and disability definition for disability benefit, if available				

Personal Priorities			
Your Health Insurance Concerns	**Level of Concerns**		
	Low	Medium	High
Cover for hospitalisation expenses	☐	☐	☐
Cover for outpatient medical expenses	☐	☐	☐
Cover for major illnesses (e.g. cancer, kidney dialysis, etc.)	☐	☐	☐
Cover for dental expenses	☐	☐	☐
Cover for old age disabilities	☐	☐	☐
Cover for loss of income due to illness or sickness	☐	☐	☐

Health Condition (Please tick boxes [√] where appropriate)		
Do you or any applicants have any medical condition, which requires you to receive regular attention from a doctor in a clinic or hospital?	☐Yes	☐No
If 'Yes', what is/are these medical condition(s)?		

Replacement of Policy (Please tick boxes [√] where appropriate)		
Is this product intended to replace any existing health insurance policy? (If yes, Advisor should state the reasons for replacement in the "Statement by Advisor" section)	☐Yes	☐No
Advisor's Declaration: I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.		
Signature of Advisor :	Date:	

"Our Advice and Reasons Why"

(Individual Health Business)

For

(Client)

By

(Insurance Advisor)

Statement by Advisor
The recommendations in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the "Know Your Client" Form.

1. Analysis and calculation worksheet

	Client	Spouse	Child
1.1 Medical Expenses (also known as Hospital/Surgical Expenses)			
Type of hospital to be covered (private/public)			
Type of room to be covered (single/double/4-bedded)			
Existing type of hospital plan covered			
Existing policy type (individual/employer group)			
1.2 Critical Illnesses			
a.Total lump sum benefit to be covered			N.A.
b. Existing lump sum benefit covered			N.A
Estimated lump sum benefit needed (a-b)			N.A.
1.3 Hospital Cash Income			
a. Existing amount covered			N.A
b. Total Amount of Cash Income to be covered			N.A
Total Amount of Cash Income Needed (b-a)			N.A

2. Advisor analysis and recommendations

Total Health Insurance Budget (if applicable): per month/per annum

Advisor's recommendations (Please tick boxes [√] where appropriate)	**Reasons for recommendations**	**Remarks**
☐Medical Expenses (also known as Hospital/Surgical Expense Protection)		Replacement Y/N
☐Critical Illness Protection		Replacement Y/N
☐ Hospital Cash Protection		Replacement Y/N
☐Others		Replacement Y/N

3. Acknowledgement
I/We understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I/we **agree / do not agree*** with the proposed recommendation(s). (* Please tick boxes [√] where appropriate))
If I/we should decide to switch from one health insurance product to another health insurance product, I/we understand that:
. ☐ I/We may not be insurable at standard terms . ☐ I/We may have to pay a different premium . ☐ Terms and conditions may defer (Please tick boxes [√] where appropriate)
Signature of client (on behalf of all applicants) :
Date :
Signature of Advisor :
Date :

For Office Use Only – INTERNAL
This section is to be completed by a qualified staff of the Insurer or Principal Firm of the Advisor.

4. Opinion of the Recommendation

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I **agree/do not agree*** with the proposed recommendation(s).
(* Please tick boxes [√] where appropriate)

Comments (necessary if in disagreement with recommendation) :

Remedial Action:
Signature :
Name :
Position :
Date :

Remarks: This plan is not a Medisave-approved plan and you may not use Medisave plan to pay the premium for this plan. If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.

Plan Owners' Protection Scheme
This plan is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your plan is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association of Singapore (GIA)/Life Insurance Association of Singapore (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).