LOGO OF INSURER (EXEMPT FA) / OTHER EXEMPT FA / FA / IFA

"**Our Advice and Reasons Why"**

for

_____

BY

_____

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	_____	_____	
b. Existing lump sum benefit covered	_____	_____	
Estimated lump sum benefit needed (a-b)	_____	_____	
1.3 Hospital Cash Income			
a. Existing amount covered	_____	_____	
b. Total Amount of Cash Income to be covered	_____	_____	
c, Total Amount of Cash Income Needed (b-a)	_____	_____	

2. Advisor analysis and recommendations

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

Advisor's recommendations	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).

If I/we should decide to switch from one health insurance product to another health insurance product, I/we understand that:

A) I/We may not be insurable at standard terms
B) I/We may have to pay a different premium
C) Terms and conditions may defer

(*Delete as 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).

Comments (necessary if in disagreement with recommendation) :

Remedial Action

Signature

Name :
Position :
Date :