GIA INSURANCE FACT FIND FORM FOR INDIVIDUAL ACCIDENT AND HEALTH BUSINESS

"Know Your Client" Form

Confidential Fact Find for

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BY

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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.

Standard statement applicable to all advisors

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

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 :

1 PERSONAL INFORMATION

1a. Personal Details of Client

Name: Mr/Mrs/Miss/Ms/Dr ____

NRIC/ Passport No.: _________________ **Date of Birth**: ____/____/____

Marital Status: Single / Married / Divorced / Separated / Widowed **Gender:** M/ F

Email Address: ___________________________ **Telephone No.**:_____________

1b. Employment Details

Current Occupation _______________ **Monthly Income Range**
1. ☐ Below $2,500
2. ☐ $2,501 to $5,000
3. ☐ $5001 & above

1c Details of Spouse & Dependants (If family coverage is required)

Name / Relationship	DOB	Gender	Occupation	Monthly Income Range (see Question 1b above)
________________	___/___/___	M/F	_________	☐ 1 ☐ 2 ☐ 3
________________	___/___/___	M/F	_________	☐ 1 ☐ 2 ☐ 3
________________	___/___/___	M/F	_________	☐ 1 ☐ 2 ☐ 3
________________	___/___/___	M/F	_________	☐ 1 ☐ 2 ☐ 3

2 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

3 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	☐	☐	☐

4 HEALTH CONDITION

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)?

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5 REPLACEMENT OF POLICY

Is this product intended to replace any existing health insurance policy? **Yes / No**
(If yes, Advisor should state the reasons for replacement in the "Statement by Advisor" section)

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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: _______________________