Individual Fact Find Form

Insurance Fact Find Form for Individual Health Business

Confidential Fact Find for ______________________________ (Client)

By ______________________________ (Insurance Advisor)

Important Notice to Clients

For General Agents/Banks

Your Insurance Advisor is a representative of ______________________________

______________________________ and can advise you on the products of

1. Insurer: ______________________________
2. Insurer: ______________________________
3. Insurer: ______________________________

For Insurance Brokers/Financial Advisors/Banks

Your Insurance Advisor 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 *Fact Find Form* may not be appropriate to your needs.

Application Type

Client's choice

☐ I/We wish to disclose all information requested for in this Form (Please complete and sign *Fact Find Form* and *Our Advice and Reasons Why Form*).

☐ I/We wish to receive product advice only (Please sign below and upon completion of Section 2 – *Our Advice and Reasons Why Form*, sign Section 3 – Acknowledgement).

☐ 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 *Fact Find Form*.

______________________________ Signature of Client (on behalf of all applicants)

______________________________ Signature of Advisor

______________________________ Date (DDMMYYYY)

______________________________ Date (DDMMYYYY)

Personal Information

Personal Details of Client

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

NRIC/Passport No.: ______________________________ Date of Birth (DDMMYYYY): ______________

Marital Status: Single / Married / Divorced / Separated / Widowed Gender (M/F): ______________

Email: ______________________________ Telephone No.: ______________

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Personal Information

Employment Details

Current Occupation: ______________________________

Monthly Income Range: 1. ☐ Below SGD 2,500 2. ☐ SGD 2,500 to SGD 5,000 3. ☐ SGD 5,001 & above

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

Name	Relationship	DOB (DDMMYYYY)	Gender	Occupation	Monthly Income Range
			M / F		☐ 1 ☐ 2 ☐ 3
			M / F		☐ 1 ☐ 2 ☐ 3
			M / F		☐ 1 ☐ 2 ☐ 3
			M / F		☐ 1 ☐ 2 ☐ 3

Existing Health Insurance Policies

This covers all Health Insurance Policies 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 out-patient 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

Do you or any applicants have any medical condition, which required 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

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)

____

Advisor's Declaration:
I declare that the information provided to me is strictly confidential and is only to be used for 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 (DDMMYYYY)

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"Our Advice and Reasons Why"
For

____

(Client)

By

____

(Insurance Advisor)

Statement by Advisor

The recommendations in this document are based on your personal information collected in the *Fact Find 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 *Fact Find Form*.

Analysis and Calculation Worksheet

	Client	Spouse	Child
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)	______	______	______
Critical Illnesses			
(a) Total lump sum benefit to be covered	______	______	______
(b) Existing lump sum benefit covered	______	______	______
Estimated lump sum benefit needed (a-b)	______	______	______
Hospital Cash Income			
(a) Existing amount covered	______	______	______
(b) Total Amount of Cash Income to be covered	______	______	______
Total Amount of Cash Income Needed (b-a)	______	______	______

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 ☐ Yes ☐ No
☐ Critical Illness Protection		Replacement ☐ Yes ☐ No
☐ Hospital Cash Protection		Replacement ☐ Yes ☐ No
☐ Others		Replacement ☐ Yes ☐ No

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Acknowledgement

I/We understand that the above recommendation(s) is/are based on the facts furnished in the *Fact Find 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.)

Personal Data Protection Statement
I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

Signature of Client (on behalf of all applicants)	Signature of Advisor
Date (DDMMYYYY)	Date (DDMMYYYY)

For Office Use Only – INTERNAL

This section is to be completed by a qualified staff of the Insurer or Principal Firm of the Advisor.

Opinion of the Recommendation

I understand that the above recommendation(s) is/are based on the facts furnished in the *Fact Find 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 (DDMMYYYY)

Please Send Completed Form to GlobalHealth Asia

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