KNOW YOUR CLIENT (Confidential Fact Find Form)

For	By (Name & Code of Advisor)

IMPORTANT NOTICE TO CLIENTS

Your insurance advisor is

◯ a representative of CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.

◯ a broker with .....

Your advisor is able to source for and objectively recommend the products of various general insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he/she sources the products.

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 completion of a "Know Your Client" form may not be appropriate to your needs.

APPLICATION TYPE

Client's Choice (please tick the appropriate box)

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).

Signature of Client (On behalf of all applicants)	Signature of Advisor
Date	Date

PLEASE COMPLETE IN BLOCK LETTERS AND INK

Tick boxes as appropriate and delete at (*) accordingly. Any amendments require the signature of the Proposer.

1 Personal Information

Full Name as shown on NRIC/FIN/Passport (Please underline surname or last name)

*Mr / Mrs / Mdm / Miss / Dr

Country of Birth	Date of Birth (dd/mm/yyyy)	Age Next Birthday

Nationality

◯ Singaporean ◯ Singapore PR ◯ Others, please specify: .....

Marital Status	Gender
◯ Single ◯ Married ◯ Widowed ◯ Divorced	◯ Male ◯ Female

Current Occupation / Nature of Work

Monthly Income Range

◯ Below S$2,500 ◯ S$2,501 to $5,000 ◯ S$5,001 & Above

Contact Details (For overseas line, please indicate Country Code and Area Code)

Home No.:	Office No.:
Mobile No. (Mandatory):	Email Address (Mandatory):

CTPIS/LIFE/SIM/102020

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

2 Details of Spouse & Dependants (if family coverage is required)

Name	Relationship	Date of Birth (dd/mm/yyyy)	Gender (M/F)	Occupation	Monthly Income Range		
					Below S$2500	S$2501 to S$5000	S$5000 & Above

3 Existing Health Insurance Policies

This covers all Health Insurance Policies you currently have (eg. CPF-approved Medical Scheme, Personal Medical, Hospital Income, Long Term Care, Employer Sponsored Scheme, etc)

Policy Type*	Insured**	Sum Insured	Annual Limit	Lifetime Limit	Annual Premium++	Expiry Date++
	◯Y ◯S ◯J					
	◯Y ◯S ◯J					
	◯Y ◯S ◯J					

* If the policy is provided by your current employer, please indicate "E" next to the policy plan.
** Y = You, S = Spouse, J = Joint
++ Please provide benefit schedule and disability definition for disability benefit, if available.

4 Personal Priorities

Your Health Insurance Needs	Level of Priority in Your Personal Needs		
	Low	Medium	High
Cover for hospital and surgical expenses	◯	◯	◯
Cover for outpatient medical expenses	◯	◯	◯
Cover for major illnesses (eg. cancer, kidney dialysis, etc)	◯	◯	◯
Cover for dental expenses	◯	◯	◯
Cover for old age disabilities	◯	◯	◯
Cover for loss of income due to illness or sickness	◯	◯	◯
Cover for health screening	◯	◯	◯

5 Health Condition

Do you or any of your dependents above have any medical condition(s) which require you or any of them to receive regular attention from a doctor in a clinic or hospital? If "Yes", what are these medical condition(s)? ◯ Yes ◯ No

6 Replacement of Policy

Is this product intended to replace any existing health insurance policy(ies)?
If "Yes", Advisor should state the reasons for replacement in the "Advisor's Analysis & Recommendation" section on page 3. ◯ Yes ◯ No

7 Declaration of Advisor

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

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8 Section 2 - "Our Advice and Reasons Why" Form

IMPORTANT NOTICE :
The recommendations in this document are based on the 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 the 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.

ANALYSIS AND CALCULATION WORKSHEET

	Yourself	Spouse	Dependant
Medical Expenses (also known as Hospital / Surgical Expenses)	S$	S$	S$
Average annual patient treatment expenses (depending on choice of ward stay)			
Average annual surgical expenses			
Total average annual medical expenses			
Less : Existing H&S policy maximum limit per annum			
Add : Deductible and Co-insurance			
Estimated level of medical expenses protection needed			
Hospital Cash Income	S$	S$	S$
Total monthly expenses			
Less : Existing disability benefit per month			
Less : Existing hospital cash benefit per month			
Estimated level of income protection needed			

ADVISOR'S ANALYSIS AND RECOMMENDATIONS

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

Advisor's recommendations	Reasons for recommendations	Remarks
◯ Medical Expenses Protection (also known as Hospital / Surgical Expenses Protection)		Replacement ◯ Yes ◯ No
◯ Hospital Cash Protection		Replacement ◯ Yes ◯ No
◯ Others		Replacement ◯ Yes ◯ No

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9 Section 3

ACKNOWLEDGEMENT

I / We understand that the above recommendation(s) is / are based on the facts furnished in the "Know Your Client" Form; and any incomplete or inaccurate information provided by me / us may affect the suitability of the recommendations made. If I / we choose not to provide information requested or accept the advisor's recommendations, then it is my / our responsibility to ensure the suitability of the health product(s) selected.

◯ I / We **agree** with the proposed recommendation(s).

◯ I / We **do not agree** with the proposed recommendation(s), based on the reasons cited below and would like to make the changes as highlighted.

.....

.....

My / Our advisor has explained the following to my / our satisfaction in the event a replacement of policy should take place.

a) I / We may incur transaction costs without gaining any real benefit from the replacement.
b) I / We may incur penalties for terminating any of my / our health existing policies.
c) I / We may not be insurable at standard terms.
d) The replacement plan may offer a lower level of benefit at a higher cost or same cost, or offer the same level of benefit at a higher cost.
e) The replacement plan may be less suitable and the terms and conditions may differ.

◯ No ◯ Yes

Signature of Client (On behalf of all applicants)

Date

Signature of Advisor

Date

ADVISOR ACKNOWLEDGEMENT

The recommendation(s) made by me is / are based on the above needs analysis which has taken into account the information disclosed by the client in the "Know Your Client" Form. The information provided to me in this "Know Your Client" Form is strictly confidential and is only to be used for the purpose of fact-finding as part of the process of recommending suitable health insurance products and shall not be used for any other purposes.

OPINION OF THE RECOMMENDATION

This section is to be completed by a qualified staff of the insurer or Principal Firm of the advisor

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form and

◯ **I agree** with the proposed recommendation(s).

◯ **I do not agree** with the proposed recommendation(s).

Comments (if in disagreement with recommendation)

.....

.....

Remedial Action proposed :

.....

.....

Signature of Authorised Officer:

Name & Position:

Date:

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