

Statement pursuant to Section 25 (5) Cap. 142 of the Insurance Act or any subsequent amendments thereof – You are to disclose in this proposal form fully and faithfully all the facts which you know or ought to know about the risk that is being proposed, otherwise the policy issued hereunder may be void.

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.: _____

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 & Dependents (If family coverage is required)

Name	Relationship	DOB (DDMMYYYY)	Gender	Occupation	Monthly Income Range		
					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	_____	_____	M / F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	_____	_____	M / F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	_____	_____	M / F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	_____	_____	M / F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for out-patient medical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for major illnesses (e.g. cancer, kidney dialysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for dental expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for old age disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for loss of income due to illness or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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) _____

“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
<input type="checkbox"/> Medical Expenses (also known as Hospital/Surgical Expense Protection)		Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Critical Illness Protection		Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hospital Cash Protection		Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Others		Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No

Acknowledgment and Personal Data Protection Act (PDPA)

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.

(*Select 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)

DECLARATION BY APPLICANT

I/We do hereby declare and warrant that:

- a) All information provided by me/us in connection with this application is true, accurate and complete. I/We have not withheld any material fact and except as declared herein all persons to be insured are currently in good health to the best of my/our knowledge and belief.
- b) I/We understand that any inaccurate, incomplete or false information given or any omission of information required, may at Liberty Insurance Pte Ltd's ("**Liberty**", the "**Company**") discretion, render this application invalid.
- c) I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.
- d) I/We agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.
- e) I/We agree to inform if there is any change in any of the details I have provided to Liberty in this application. I understand and agree that it is my sole responsibility to inform and update Liberty of any changes to the health or personal information of any person to be insured. I hereby agree to indemnify and absolve Liberty of any liability arising out of any use and/or disclosure by Liberty of any inaccurate or incomplete information due to my failure to update Liberty promptly of any changes to the health or personal information of any person to be insured.

Signature of Client (on behalf of all applicants)

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 APRIL Singapore Pte Ltd

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
51 Club Street #03-00 Liberty House
Singapore 069428
Tel : 1800-LIBERTY(5423 789)

Arranged and administered by:

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