Individual Fact Find Form

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 :	DD / MM / YYYY	Date :	DD / MM / YYYY

PERSONAL INFORMATION

Personal Details of Client

Name:	◎Mr / ◎Mrs / ◎Miss / ◎Ms / ◎Dr		
NRIC/Passport No.:		Date of Birth:	DD / MM / YYYY
Marital Status:	◎Single / ◎Married / ◎Divorced / ◎Separated / ◎Widowed	Gender:	Male ◎ Female ◎
Email:		Tel.:	

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	Gender	Occupation	Monthly Income Range
		DD / MM / YYYY	◎ **M** ◎ **F**		◎ **1** ◎ **2** ◎ **3**
		DD / MM / YYYY	◎ **M** ◎ **F**		◎ **1** ◎ **2** ◎ **3**
		DD / MM / YYYY	◎ **M** ◎ **F**		◎ **1** ◎ **2** ◎ **3**
		DD / MM / YYYY	◎ **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? If Yes, what is/are these medical condition(s)?	Yes ○	No ○

REPLACEMENT OF POLICY

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

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	

OUR ADVICE AND REASONS WHY

For		**By**	
	(Client)		(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 ◎

ACKNOWLEDGMENT & PERSONAL DATA PROTECTION ACT (PDPA)

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 Insurance 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, 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.

DECLARATION BY APPLICANT

I/We do hereby declare and warrant that:
I/We hereby confirm this declaration is correct and consent to disclose personal data to APRIL and the insurer.
nol/We and my dependents have read, understand, and consent to **Liberty Insurance Data Protection** and **APRIL Singapore Privacy Notice**, and if my dependents are minors, I am providing such consent as parent or legal guardian of such minors.

DECLARATION BY APPLICANT

I declare that the statements contained in this form are correctly recorded, and that they are full, complete and true. I further declare that I have not withheld any material fact and that except as declared herein. I will notify APRIL Singapore Limited immediately if after signing this form and before a policy is issued I become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, the statements made herein shall form the basis of the policy between me/us and Liberty International Insurance Limited. In the event that the provided information is not true or complete, I understand and further agree that the premium could be changed; the insurance contract could be declared void; or the insurance company is entitled to deny its responsibility for any material misrepresentation of non-disclosure. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

SIGNATURE OF CLIENT (ON BEHALF OF ALL APPLICANTS)

Date :	DD / MM / YYYY

I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the requirements of this Fact-Finding form to him / her.

SIGNATURE OF ADVISOR

Date :	DD / MM / YYYY

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):			
SIGNATURE		Remedial Action:	
		Name:	
		Position:	
		Date:	

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Liberty Insurance or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).
This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.
This is a short-term accident and health policy and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you 30 days' notice in writing.

MH SG 2025/01

Underwritten by:
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Registration No. 199002791D
GST Registration No. M2-0093571-3
One Raffles Quay #25-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY(5423 789)

Arranged by:
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Co. Reg. No. 200613924G
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Singapore 069043
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