Liberty Insurance Pte Ltd
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Singapore 048583
Tel: 1800-LIBERTY (542 3789)
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Fact-Find for Individual – Accident & Health

Please complete all sections to faciliate the processing of your application.

Statement pursuant to Section 23(5) of the Insurance Act 1966 or any subsequent amendments thereof. You are to disclose in the proposal form fully and faithfully all facts which you know or ought to know, otherwise the Policy issued hereunder may be void.

Confidential Fact-Find for
Name of Client: _____

Name of Producer & Producer Code: _____

Important Notice to Clients

For General Agents/Banks:
Your insurance advisor is a representative of **Liberty Insurance Pte Ltd** and can advise you on the products of:

1. Name of Insurer: Liberty Insurance Pte Ltd
2. Name of Insurer: _____
3. Name of Insurer: _____

For Insurance Brokers/Financial Advisers/Banks:
Your insurance advisory is a broker with:

(Name of Broker 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.

Type of Application

Client's Choice

☐ I/We wish to disclose all information requested for in this Form (Please complete and sign section 1 "Know Your Client" and section 2 "Our Advice and Reasons Why" forms)

☐ 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")

☐ I/We do not wish to receive any advice from my/our advisor. (Please sign below)

Fact-Find for Individual – Accident & Health

Name of Client:	_____
Name of Producer & Producer Code:	_____

I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.

_____	_____
Signatory of Advisor	Signatory of Client (on behalf of all applicants)
_____	_____
Date	Date

1. Know your Client

Particulars of Client

Name of Client: _____		NRIC/FIN No.: _____
Date of Birth: _____	Marital Status: Please select	Gender: Please select
Email: _____		Contact No.: _____

Details of Employment

Occupation: _____	Range of Monthly Income: Please select

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

Name	Relationship	Date of Birth	Gender	Occupation	Monthly Income[1]
			Please select		
			Please select		
			Please select		
			Please select		
			Please select		

[1] Reference range of monthly income as above

Fact-Find for Individual – Accident & Health

Name of Client:	_____
Name of Producer & Producer Code:	_____

Details of 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)

Type of Policy[2]	Insured[3]	Type and Amount of Benefit[4]	Annual Premium[4]	Expiry Date[4]

[2] Individual or group policy from employer
[3] Y=You; S=Spouse; J=Joint
[4] Please provide Schedule of Benefits and disability for disability benefit if available

Personal Priorities

Your Health Insurance Concerns	Level of Concerns
Cover for hospitalisation expenses	Please select
Cover for outpatient medical expenses	Please select
Cover for major illnesses (e.g., cancer, kidney dialysis etc)	Please select
Cover for dental expenses	Please select
Cover for old age disabilities	Please select
Cover for loss of income due to illness or sickness	Please select

Health Conditions

Do you or any applicants have any medical condition, which requires you to receive regular attention from a doctor in a clinic or hospital? If yes, what is/are these medical condition(s)? _____	Please select

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.	Please select

Fact-Find for Individual – Accident & Health

Name of Client:	_____
Name of Producer & Producer Code:	_____

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.

_____ _____

Date Signature of Advisor

2. Our Advice and Reasons Why

Particulars of Client

Name of Client:	_____
Name of Producer & Producer Code:	_____

Statement by Advisor

The recommendations in this document are based on your personal 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 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 "Know Your Client" Form.

Analysis & Calculation Worksheet

	Client	Spouse	Child
Medical Expenses (also known as Hospital/Surgical Expenses)			
a) Type of Hospital to be covered (public/private)			
b) Type of room to be covered (single/double/4-bedded)			
c) Existing type of hospital plan covered			
d) Existing type of policy (individual/employer group)			
Critical Illnesses			
a) Total lump sum benefit to be covered			
b) Existing lump sum benefit covered			
c) Estimate lump sum benefit needed (a-b)			
Hospital Cash Income			
a) Existing amount covered			
b) Total amount of cash income to be covered			

Name of Client:	_____
Name of Producer & Producer Code:	_____

	Client	Spouse	Child
c) Total amount of cash income needed (b-a)			

3. Advisor's Analysis & Recommendations

Total Health Insurance budget (if applicable):		S$	Per month/annum
Advisor's Recommendations	Reasons for Recommendations	Remarks	
☐ Medical Expenses (also known as Hospital/Surgical Expense Protection)		Replacement:	Please select
☐ Critical Illness Protection		Replacement:	Please select
☐ Hospital Cash Protection		Replacement:	Please select
☐ Others		Replacement:	Please select

ACKNOWLEDGEMENT

I/We understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I/we **agree/do not agree**[5] 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

[5] Delete as appropriate

DECLARATION

I, the Proposer, declare and warrant that:

a) All information provided by me/us in connection with this application are true, accurate and complete
b) I agree that this application and declaration shall be the basis of the contract between Liberty and myself
c) I agree to accept the Company's policy subject to the terms, exclusions, and conditions to be expressed therein, endorsed thereon or attached thereto
d) If I do not fully and faithfully give the facts as I know them or ought to know them, I may receive nothing from the policy
e) I agree to the policy terms, exclusions, and conditions as expressed in the brochure, proposal form, policy wordings and endorsements
f) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at www.libertyinsurance.com.sg/data-protection-policy, both now & in advance as it may be amended from time to time

IMPORTANT NOTICE TO SUBMITTER

If you, the submitter of this form, are submitting this form for another person who is the actual Proposer; and in consideration for Liberty processing this application upon your request:

a) You agree that you have been validly & legally authorised by the Proposer to do so; and

Name of Client:	_____
Name of Producer & Producer Code:	_____

b) You warrant that you have shown this entire completed document to the intended Proposer and had obtained his/her agreement to everything; and

c) You, in your personal capacity, agree to indemnify and keep Liberty Insurance Pte Ltd indemnified against all proceedings, costs, expenses, claims, liabilities, losses or damages if any part of this Notice turns out to be false, howsoever whatsoever, on a strict liability basis, that is, even if your state of mind was unintentional, intentional, negligent, inadvertent, accidental, unknowing, etc

_____ _____

Signatory of Advisor

Signatory of Client
(On behalf of all applicants)

4. Opinion of the Recommendation

For Office Use Only Internal:

This section is to be completed by a qualified staff of the Insurer of 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

Please select

Comments:
(Necessary if in disagreement with the recommendation) _____

Remedial Action: _____

_____ _____

Date

Signatory

_____

Name

_____

Designation

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 us (servicecenter@libertyinsurance.com.sg) or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).