GIA FACT FIND FORM
For Individual Health Insurance

"Know Your Client" Form
Confidential Fact Find Form

CLIENT: _____

INSURANCE ADVISOR: _____

- Who is a representative of **Sompo Insurance Singapore Pte. Ltd.** (for General agents)

- Who is a broker with _____ (for Brokers/Financial Advisors)

AND Can advise you on the products of: _____

_____

IMPORTANT NOTICE TO CLIENTS

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.

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.

APPLICATION TYPE

Client's choice (☑ Please tick)

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)

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

Signature of client (on behalf of all applicants): _____
Date:

Signature of Advisor: _____
Date:

Sompo Insurance Singapore Pte. Ltd.
50 Raffles Place #03-03 Singapore Land Tower Singapore 048623
Tel: 6461 6555 Fax: 6221 3302
Company Registration No. 198905490E www.sompo.com.sg

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1. PERSONAL INFORMATION

Name: _____ **Nationality:** _____

NRIC/PP No.: _____ **Date of Birth**: _____ **Marital Status:** _____ **Gender:** M/ F

Occupation _____ **Business/Trade:** _____

Monthly Income Range ☐ Below $2,500 ☐ $2,501 to $5,000 ☐ $5,001 & above

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

Relation	Name	NRIC/PP No.	DOB	Occupation & Biz/Trade	Sex	W (kg)	Ht (m)
Spouse							
	Monthly Income Range ☐ Below $2,500 ☐ $2,501 to $5,000 ☐ $5,001 & above						
Child							
Child							
Child							

2. EXISTING HEALTH INSURANCE POLICIES

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

Policy Type*	Insured Person(s)	Sum Insured	Annual Premium	Expiry Date

* Please specify if the policy is provided by your current employer

3. PERSONAL PRIORITIES

Your Health Insurance Needs (☑ Please tick)	**Level of Priority in Your Personal Needs** Low	Medium	High
Cover for hospitalisation expenses	—	—	—
Cover for outpatient 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	—	—	—

4. HEALTH CONDITION

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)? **Yes / No**

_____

5. 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 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: _____

GIA FACT FIND FORM
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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 the information collected in the "Know Your Client" Form. If there have been any changes 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.

1. NEEDS ANALYSIS CALCULATION WORKSHEET

A. MEDICAL EXPENSES (also known as Hospital / Surgical Expenses)	**CLIENT**	**SPOUSE**	**CHILD**
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			
B. HOSPITAL CASH INCOME			
a. Existing amount covered			
b. Total Amount of Cash Income to be covered			
c. Total Amount of Cash Income Needed (b-a)			

2. ADVISOR ANALYSIS AND RECOMMENDATIONS

Advisor's recommendations	**Reasons for recommendations**	**Remarks**
Medical Expenses (also known as Hospital/Surgical Expense Protection)		
Hospital Cash Income Protection		
Others		

3. 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 with the proposed recommendation(s).
- I/We acknowledge and agree (in case of corporate policy, I represent that I have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my/our personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg
- I/We consent to receive marketing and promotional information from Sompo (e.g. via email, mail, SMS, etc.). I/We understand that I/We can withdraw or manage my/our consent to receive marketing and promotional information at www.sompo.com.sg
- I/We am/are aware of and agree to abide by the Policy terms, conditions and exclusions and confirm that the information given in this application/form is true, accurate and complete.

Signature of client (on behalf of all applicants) : _____
Date : _____

Signature of advisor : _____
Date : _____

Note: If insurance intermediary should recommend that a client switch from one health insurance products to another insurance products, he should ensure that the following factors are explained to the clients:-
(A) You may not be insurable at standard terms
(B) You may have to pay a different premium
(C) Terms and conditions may defer

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 "Know Your Client" Form; and I

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

Comments (necessary if in disagreement with recommendation):

Remedial action

Name of Authorised Officer: _____

Signature _____

Date _____