HSBC Life (Singapore) Pte. Ltd.
10 Marina Boulevard,
Marina Bay Financial Centre Tower 2 #48-01,
Singapore 018983
+65 6880 4888
www.hsbclife.com.sg
GST Reg No. 199903512M
Co. Reg No. 199903512M

Individual Fact Find Form

Confidential Fact Find form	By your Financial Planner	
(Client's Name)	(Name of Financial Planner)	(Account Code)
	(Contact number of Financial Planner)	

Important Notice to Clients

For General Agents/Banks

Your Financial Planner is a representative with **HSBC Life** and can advise you on the products of:

1) HSBC Life (Singapore) Pte. Ltd. 2) _____ 3) _____

For Insurance Brokers/Financial Planner/Banks

Your insurance advisory is a broker with _____.

As an insurance broker, your Financial Planner is able to source for and objectively recommend the products of various insurance companies to best meet your insur-ance needs. Your Financial Planner is required to disclose to you the insurance companies from which he/she sources the products.

Standard Statement Applicable to All Financial Planner:

Your Financial Planner 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

1. ❑ I/We wish to disclose all information requested for in this Form. (Please **sign below** and complete Sections "**A** Know Your Client", "**B** Our Advice and Reasons Why" and "**C** Declaration for Product Summary")
2. ❑ I/We wish to receive product advice only. (Please **sign below** and complete Sections "**B** Our Advice and Reasons Why" and "**C** Declaration for Product Sum-mary")
3. ❑ I/We do not wish to receive any advice from my/our Financial Planner. (Please **sign below** and complete Section "**C** Declaration for Product Summary")

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

Financial Planner'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 Client (on behalf of all persons to be insured)
Date: (ddmmyyyy)

Signature of Financial Planner
Date: (ddmmyyyy)

A. Know Your Client

1. Personal Information

a. **Personal Details of Applicant to be Insured**

Full Name: ❑ Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Dr _____ NRIC/ Passport No.: _____

Date of Birth: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Gender: ❑ Male ❑ Female

Email Address: _____ Contact Number: _____

b. **Employment Details of Applicant to be Insured**

Employment Status

❑ Full-time ❑ Part-time ❑ Self Employed ❑ Not Employed ❑ Retired ❑ Others: _____

Monthly Income Range

❑ Below $2,500
❑ $2,501 to $5,000
❑ $5001 & above

Type of Work Passes:
Employment Pass / S-Pass / Work Permit / Not Applicable

Current Occupation: _____

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

	Full Name	Date of Birth (dd/mm/yyyy)	Gender		Employment Status (See Question 1b above for options)	Monthly Income Range		
			Male	Female		Below $2,500	$2,501 to $5,000	$5001 & above
Spouse			❑	❑		❑	❑	❑
Child 1			❑	❑		❑	❑	❑
Child 2			❑	❑		❑	❑	❑
Child 3			❑	❑		❑	❑	❑

d. **Other Sources of Income**

1.	Monthly Amount: S$	Activity:	
2.	Monthly Amount: S$	Activity:	
3.	Monthly Amount: S$	Activity:	

2. Existing Insurance Portfolio

This information helps to evaluate if your existing insurance portfolio is adequate in meeting your financial needs.

Would you like your existing insurance portfolio to be taken into consideration for the Needs Analysis and Recommendation(s)?

❑ No, please state reason:

_____

_____

❑ Yes, please complete the details below:

Summary of Existing Portfolio

Name of Insured	Types of Benefit (e.g Health or Personal Accident)	Total Benefit Amount (S$) (e.g Sum Insured/ Maturity Value)	Annual Premium	Does policy cover the applicant or dependants or both?		
				Applicant Only	Dependants Only	Both
				❑	❑	❑
				❑	❑	❑
				❑	❑	❑
				❑	❑	❑

3. Cash Flow and Budget

a. **Cash Flow**

This information helps to ascertain the affordability of the recommendation(s) and plan(s) for your financial need(s).

Would you like your cash flow to be taken into consideration for the Needs Analysis and Recommendation(s)?

❑ No, please state reason:

_____

_____

❑ Yes, please complete the details below:

Estimated total annual income: S$_____

Estimated total annual expenses: S$_____

Surplus / Shortfall: **S$**_____

Do you have any plans or are there any factors within the next 12 months which may significantly increase or decrease your current income and expenditure position (e.g. receiving an inheritance or borrowing money for investment or purchase of a holiday home, etc.)?

❑ No ❑ Yes (If Yes, please complete the details below)

Remarks: _____

_____

b. **Budget**

Annual Amount: S$_____ Source of this fund: _____

Single Amount: S$_____ Source of this fund: _____

Is the budget you set aside a substantial portion of your assets or surplus? ❑ No ❑ Yes

If your answer is "Yes", you may encounter a potential risk in the future of not being able to continue paying your premiums.

Note: Budget is considered substantial if it is more than 50% of assets or surplus.

4. Assets and Liabilities

This information helps to facilitate the planning of your financial needs.

Would you like your assets and liabilities to be taken into consideration for the Needs Analysis and Recommendation(s)?

❑ No, please state reason: _____

_____

❑ Yes, please complete the details below:

a. **Assets** Client

Personal Use Assets (E.g. family home, home contents, real estate, motor vehicle)	S$_____
Investment (E.g. shares, bonds, debentures, insurance, managed investments)	S$_____
CPF	S$_____
Others (E.g. cash, bank deposit, collectibles, jewellery)	S$_____
Total assets	S$_____

b. **Liabilities**

Loans (E.g. home mortgage, investment loan, car loan, personal loan)	S$_____
Liabilities (E.g. credit card, annual tax liability)	S$_____
Total liabilities	S$_____

Combined

Total assets	S$_____
Less total liabilities	S$_____
Net asset position	S$_____

5. Personal Priorities (Please tick)

a.

Your Health Insurance Concerns	**Level of Concerns**		
	Low	**Medium**	**High**
Cover for hospitalisation expenses	❑	❑	❑
Cover for outpatient medical expenses	❑	❑	❑
Cover for major illnesses (e.g. cancer, kidney dialysis)	❑	❑	❑
Cover for loss of income due to illness or sickness	❑	❑	❑

b. **What you are looking for**

Nature of benefits payment

❑ Lump sum payment ❑ Periodical payments ❑ Actual cost incurred by you or your insured dependants

6. Replacement of Policy

Is this product intended to replace any existing accident or health insurance policy? ❑ Yes ❑ No

If yes, Financial Planner should state in **"B2 Financial Planner Analysis and Recommendation"** section:

a) reasons for replacement
b) fee or charge policy owner has to bear
c) changes in level of benefits

7. Medical Insurance for Migrant Worker (Applicable for S-Pass / Work Permit holders only)

Do you intend to buy a medical insurance for your migrant worker that comply with the Ministry of Manpower's (MOM) enhanced Medical Insurance requirements? ❑ Yes ❑ No

B. Our Advice and Reasons Why

B1 – Analysis and Calculation Worksheet

a. Medical Expenses (also known as Hospital / Surgical Expenses)	**Client**	**Spouse**	**Child**
i. What is the type of hospital preferred in the event of hospitalisation? **(private/public)**			
ii. What is the type of hospital ward preferred in the event of hospitalisation? **(1/2/4/6 bedded)**			
iii. Is there an existing hospitalisation insurance plan? **(Yes/ No)**			
iv. If **Yes** is selected for part iii, what is the existing policy type? **(individual policy/ group employee benefits)**			

b. Critical Illnesses	**Client**	**Spouse**
i. What is the total lump sum benefit required (S$) in the event of being diagnosed with a critical illness?		
ii. Is there an existing critical illness insurance plan? **(Yes/ No)**		
iii. If **Yes** is selected for part ii, what is the existing sum insured amount (S$)?		
Estimated lump sum benefit needed (i - iii		

c. Hospital Cash Income	**Client**	**Spouse**	**Child**
i. What is the daily cash income amount required (S$) in the event of being hospitalised?			
ii. Is there an existing hospital income insurance plan? **(Yes/ No)**			
iii. If **Yes** is selected for part ii, what is the existing amount covered (S$)?			
Estimated cash income needed (i - iii)			

B2 – Financial Planner Analysis and Recommendations

Total Health Insurance Budget: S$ _____ per month/ per year **(*Circle as appropriate.)**

Advisor's Recommendations	**Reasons for Recommendations**	**Is this product intended to replace any existing accident or health insurance policy?**
❑ Hospital/ Surgical Expense Protection		❑ Yes ❑ No Medical Insurance for migrant worker: ❑ Yes ❑ No
❑ Critical Illness Protection		❑ Yes ❑ No
❑ Hospital Cash Income Protection		❑ Yes ❑ No
❑ Others: _____		❑ Yes ❑ No

Note: If this product is intended to replace any existing health insurance policy, Financial Planner should state the reasons for recommending a replacement.

If you intend to switch from your other accident or health insurance policy to this replacement policy:

a. the fee or charge that you have to bear is _____
b. the changes in level of benefits will be:

	Original Policy	**Replacement Policy**
Insurer and Product Name		
Sum Assured		
Benefits / Coverage		
Duration of Coverage		
Premiums		
Other Differences (if any)		

B3 – Acknowledgement

Client's Declaration:

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*** with the proposed recommendation(s). **(*Circle as appropriate.)**

If I/we should decide to switch from another accident or health insurance policy to this replacement policy, the Financial Planner has informed me/us of:

a) the fee or charge I/we have to bear ❑ Yes ❑ No

b) the changes in level of benefits ❑ Yes ❑ No

Statement by Financial Planner:
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/our knowledge. If there has been any change in your circumstances since completing that form, please notify your Financial Planner 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.

Signature of Client (on behalf of all persons to be insured)
Date: (ddmmyyyy)

Signature of Financial Planner
Date: (ddmmyyyy)

C. Declaration For Product Summary

I hereby confirm that the following documents were given and the contents have been explained to me satisfactorily;
(a) Your Guide to Health Insurance and;
(b) Product Summary

Signature of Client (on behalf of all persons to be insured)
Date: (ddmmyyyy)

Signature of Financial Planner
Date: (ddmmyyyy)

For Office Use Only – INTERNAL

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