

Individual Fact Find Form

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

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 insurance 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 Summary")
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 | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child 1 | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child 2 | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child 3 | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 S\$ _____
 (E.g. family home, home contents, real estate, motor vehicle)

Investment S\$ _____
 (E.g. shares, bonds, debentures, insurance, managed investments)

CPF S\$ _____

Others S\$ _____
 (E.g. cash, bank deposit, collectibles, jewellery)

Total assets S\$ _____

b. Liabilities

Loans S\$ _____
 (E.g. home mortgage, investment loan, car loan, personal loan)

Liabilities S\$ _____
 (E.g. credit card, annual tax liability)

Total liabilities S\$ _____

Combined

Total assets S\$ _____

Less total liabilities S\$ _____

Net asset position S\$ _____

5. Personal Priorities (Please tick)

| 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 outpatient medical expenses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cover for major illnesses (e.g. cancer, kidney dialysis) | <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"/> |

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 (\$\$) 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 (\$\$)? | | |
| Estimated lump sum benefit needed (i - iii) | | |

| c. Hospital Cash Income | Client | Spouse | Child |
|---|--------|--------|-------|
| i. What is the daily cash income amount required (\$\$) 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 (\$\$)? | | | |
| Estimated cash income needed (i - iii) | | | |

B2 – Financial Planner Analysis and Recommendations

Total Health Insurance Budget: \$\$ _____ 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? |
|--|-----------------------------|--|
| <input type="checkbox"/> Hospital/ Surgical Expense Protection | | <input type="checkbox"/> Yes <input type="checkbox"/> No Medical Insurance for migrant worker: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Critical Illness Protection | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Hospital Cash Income Protection | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Others: _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> 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:

- the fee or charge that you have to bear is _____
- 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) |