EQ HOSPITAL & SURGICAL PLAN - INDIVIDUAL FACT FIND FORM

Confidential Fact Form for: (Client's Name)	By your Insurance Advisor: (Name of Advisor)

IMPORTANT NOTICE TO CLIENTS

For General Agents / Banks
Your insurance advisor is a representative with EQ Insurance and can advise you on the products of:

1)EQ Insurance Company Limited 2) _____ 3) _____

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

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 / she 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.

APPLICATION TYPE

Client's Choice is (Please tick ☑ in the appropriate box and sign below):

☐ I / We wish to disclose all information requested for in this Form. (Please complete and sign **Section A** "Know Your Client", **Section B** "Our Advice and Reasons Why", and **Section C** "Declaration and Product Summary")

☐ I / We wish to receive product advice only. (Please complete and sign **Section B** "Our Advice and Reasons Why", and **Section C** "Declaration and Product Summary")

☐ I / We do not wish to receive any advice from my / our advisor. (Please complete and sign **Section C** "Declaration and Product Summary")

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

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

SECTION A. KNOW YOUR CLIENT

1. Personal Information

1a. Personal Details of Applicant

Full Name (to underline Surname): Mr / Mrs / Ms / Mdm / Dr		NRIC / FIN No:
Date of Birth (dd / mm / yy):	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
Gender: ☐ Male ☐ Female	Email:	Contact No.:

1b. Employment Details

Current Occupation:
Employment Status: ☐ Full-Time ☐ Part-time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ Others: _____
Monthly Income Range: ☐ Below S$2,500 ☐ S$2,501 to S$5,000 ☐ S$5,001 & above

1c. Details of Spouse & Dependents (if family coverage is required)

Name / Relationship	Date of Birth (dd / mm / yyyy)	Gender	Employment Status	Monthly Income Range		
				Below S$2,500	S$2,501 to S$5,000	S$5,001 & above
		☐ M / F ☐		☐	☐	☐
		☐ M / F ☐		☐	☐	☐
		☐ M / F ☐		☐	☐	☐
		☐ M / F ☐		☐	☐	☐

1d. 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

2a. Summary of Existing Portfolio

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

3. Cash Flow and Budget

3a. 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 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

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:

_____

3b. 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 answer is "Yes", you may encounter a potential risk in the future of not being able to continue paying your premiums.

Practice 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:

Assets	**Client**	**Liabilities**	**Client**
Personal Use Assets (e.g. family home, home contents, real estate, motor vehicle)	S$	**Loans** (e.g. home mortgage, investment loan, car loan, personal loan)	S$
Investment (e.g. shares, bonds, debentures, insurance, managed investments)	S$	**Liabilities** (e.g. credit card, annual tax liability)	S$
CPF	S$		
Others (e.g. cash, bank deposit, collectibles, jewellery)	S$		
Total assets	S$	**Total liabilities**	S$

Combined	
Total assets	S$ _____
Less total liabilities	(S$ _____)
Net asset position	S$ _____

5. Personal Priorities

Your Accident & 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, etc.)	☐	☐	☐
Cover for dental expenses	☐	☐	☐
Cover for old age disabilities	☐	☐	☐
Cover for loss of income due to illness or sickness	☐	☐	☐
Cover for expenses due to accidents	☐	☐	☐

What You Are Looking For

Nature of benefits payment

☐ Lump sum payment ☐ Periodical payment ☐ Actual cost incurred by you or your insured dependents

6. Replacement of Policy

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

If yes, Advisor should state the :

a) Reason for replacement

b) Fee or charge policy owner has to bear

c) Changes in level of benefits

SECTION B. OUR ADVICE AND REASONS WHY

1. Analysis and calculation worksheet

Medical Expenses (also known as Hospital / Surgical Expenses)	Client	Spouse	Child
1. What is the type of hospital preferred in the event of hospitalisation? (private / public)			
2. What is the type of room preferred in the event of hospitalisation? (1 / 2 / 4 / 6 bedded)			
3. Do you have existing hospitalisation insurance plan? (Yes / No) If Yes, what is your existing policy type? (individual / group employer benefits)			
4. Do you have existing critical illness insurance plan? (Yes / No) If Yes, what is the existing sum insured amount? (S$)			
5. Do you have existing hospital income insurance plan? (Yes / No) If Yes, what is the existing covered amount? (S$)			

2. Advisor Analysis and Recommendations

Total Health Insurance Budget (if applicable): _____ per month / per annum.

Advisor's recommendations	Reasons for recommendations	Remarks
☐ Hospital / Surgical Expense Protection		Replacement Y / N

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 Insured		
Benefits		
Coverage		
Duration of coverage		
Premiums		
Differences		

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

If I / we should decide to switch from another accident or health insurance policy to this replacement policy, the advisor 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

(*Delete as appropriate)

Statement by Advisor:
The recommendation in this document are based on your personal information collected in the "Know Your Client" section, 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" section.

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

Signature of Advisor
Date:

SECTION 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

I/We declare and warrant that:

1. All statements and answers in this application together with any required questionnaires or document are full, complete, true and correct and that no information or material has been withheld to affect acceptance of this application.
2. This application shall form the basis of the contract between EQ Insurance and myself/ourselves and for corporate policy, on behalf of the individuals under this policy, and agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto, I/we understand that if any of the information is not full or complete or true or correct, the Policy issued hereunder may be void and I/we may receive nothing from the policy.
3. I/We am aware that I/We can seek advice from a qualified advisor before signing this proposal form. Should I/We choose not to, I/We shall take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.
4. There is no awareness of any circumstances which is likely to lead to a claim under this policy at the point of this application.
5. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
6. I/We understand that this Policy shall only be effective following the full annual premium payment and subject to the acceptance and approval of this application by EQ Insurance.
7. I/We confirm that I have been given referred to a copy of "Your Guide to Health Insurance" at https://www.eqinsurance.com.sg/Product/eq-hospital-surgical and read through the Product Summary (as stated in the brochure), the contents of which have been explained to me/us to my/our satisfaction.
8. I/We have agreed and consented (in case of corporate policy, I/we represent the same from the individuals in relation to this policy) that EQ Insurance may collect, use, disclose and/or process my/our personal data and disclose such relevant information to EQ Insurance's group companies, business partners, intermediaries, third party service providers, reinsurers, legal process participants and their advisers, governmental / regulatory authorities, industry associations, courts and other alternative dispute resolution forums, for the purposes and uses described in EQ Insurance's Personal Data Protection Statement at https://www.eqinsurance.com.sg (including the provision of the protection, services related to the insurance application, screening activities in accordance with legal I/regulatory obligations/risk management procedures).

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

Signature of Advisor
Date:

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