RafflesHealthInsurance
Your Specialist Health Insurer

"KNOW YOUR CLIENT"

Confidential Fact Find Form

For

(Name of Client)

By

(Name & Code of Representative)

IMPORTANT NOTICE TO CLIENTS

Your insurance representative is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your representative is required to disclose to you the insurance companies from which he/she sources the products.

For General Agents
Your insurance advisor is a representative of Raffles Health Insurance Pte. Ltd., and can advise you on the products of:

1. Insurer: Raffles Health Insurance Pte. Ltd.
2. Insurer: _____
3. Insurer: _____

For Insurance Brokers / Financial Advisors
Your insurance advisory is a broker/ FAR with _____
(name of company)

Standard Statement Applicable to All Advisors
Your insurance representative 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 completion of a "**Know Your Client**" form and "**Our Advice and Reasons Why**" sections of this form or following partial or inaccurate completion may not be appropriate to your needs.

APPLICATION TYPE

Client's Choice (please tick the appropriate box ☐) **:**

1. ☐ I/We have disclosed relevant information for comprehensive planning (Please complete and sign "Know Your Client" and "Our Advice and Reasons Why" forms).
2. ☐ I/We have disclosed relevant information for specific need(s) planning. (Please complete and sign "Know Your Client" form, Section 2 – Representative Analysis And Recommendations and Section 3 – Acknowledgement).
3. ☐ I/We did not undergo any needs analysis in this review and it is my/our responsibility to ensure that the Product I/We have selected is suitable. (Please complete and sign Application Type and complete the Personal Information)

I/We acknowledge that my/our representative has provided me/us with a copy of the completed "Know Your Client" Form.I/ We acknowledge I/ we have read and understood the Personal Data Protection Notification on Section 5 of this form and give consent to Raffles Health Insurance Pte. Ltd, its associated persons/ organisations and/ or its or their representatives, whether within Singapore or outside Singapore ("RHI") and its or their third party service providers to collect, use, disclose, store, retain and/or process all personal data and information that had/ has been provided to RHI and/or that RHI may possess about me/us for the Purposes.

Signature of Client : _____
(On behalf of all applicants under the family cover)
Date :

Signature of Representative : _____
Date :

Personal Information

Name of Client ☐Dr ☐Mr ☐Mrs ☐Miss		NRIC / Passport No.	Date of Birth (ddmmyyyy)	
Gender ☐ Female ☐ Male	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Nationality	Singapore PR ☐ Yes ☐ No	Age
Email Address		Contact No. (Home / Office / Mobile)		
Current Occupation / Nature of Work		Monthly Income Range ☐ Below $2,500 ☐ $2,501 to $5,000 ☐ $5,001 & Above		

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

Name	Relationship	Date of Birth (ddmmyyyy)	Gender (M/F)	Occupation	Monthly Income Range		
					Below $2,500	$2,501 to $5000	$5,000 & Above

Existing Health Insurance Policies

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

Policy Type*	Insured**	Sum Insured	Annual Limit	Lifetime Limit	Annual Premium++	Expiry Date++
	☐ Y ☐ S ☐ J					
	☐ Y ☐ S ☐ J					
	☐ Y ☐ S ☐ J					

***** If the policy is provided by your current employer, please indicate **"E"** next to the policy plan.

****** Y = You, S = Spouse, J = Joint

++ Please provide benefit schedule and disability definition for disability benefit, if available

Personal Priorities

Your Health Insurance Needs	Level of Priority in Your Personal Needs		
	Low	Medium	High
Cover for hospital and surgical expenses	☐	☐	☐
Cover for outpatient medical expenses	☐	☐	☐
Cover for major illnesses (eg. 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 health screening	☐	☐	☐

Health Condition

Do you or any of your dependents above have any medical condition(s) which require you or any of them to receive regular attention from a doctor in a clinic or hospital? ☐ Yes ☐ No

If "Yes", what are these medical condition(s)?

_____

Replacement of Policy

Is this product intended to replace any existing health insurance policy(ies)? ☐ Yes ☐ No

If "Yes", Representative should state the reasons for replacement in the "Representative Analysis & Recommendation" section on page 3.

Representative'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 Representative : _____ Date : _____

"Our Advice and Reasons Why" Form

STATEMENT BY REPRESENTATIVE:
The recommendations made 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 the form, please notify your representative 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.

SECTION 1. ANALYSIS AND CALCULATION WORKSHEET

	Client	Spouse	Child 1	Child 2	Child 3
1. **Medical Expenses (also known as Hospital / Surgical Expenses)**					
Type of hospital to be covered (private/ public)					
Type of room to be covered (e.g. single/ double/ 4-bedded)					
Existing type of hospital plan covered					
Existing policy type (individual/ employer group)					
2. **Hospital Cash Income**					
Total monthly expenses					
Less : Existing disability benefit per month					
Existing hospital cash benefit per month					
Estimated level of income protection needed					

SECTION 2. REPRESENTATIVE ANALYSIS AND RECOMMENDATIONS

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

Representative's Recommendations	Reasons For Recommendations	Remarks
☐ Medical Expenses Protection (also known as Hospital / Surgical Expenses Protection)		Replacement Policy : Yes / No
☐ Hospital Cash Protection		Replacement Policy : Yes / No
☐ Others		Replacement Policy : Yes / No

SECTION 3. CLIENT ACKNOWLEDGEMENT

1. I/We understand that the above recommendation(s) is/are based on the facts furnished by me/ us in the "Know Your Client" Form; and

☐ I/We **agree** with the proposed recommendation(s).

☐ I/We **do not agree** with the proposed recommendation(s), based on the reasons cited below and would like to make the changes as highlighted.

_____

_____

_____

2. 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 differ.

Signature of Client : _____
(On behalf of all applicants under the family cover)

Signature of Representative : _____

Date :

Date :

SECTION 4. OPINION OF THE RECOMMENDATION

This section is to be completed by a authorised/ qualified staff of the Insurer or Principal Firm of the Representative

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

☐ I **agree** with the proposed recommendation(s).

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

Comments (if in disagreement with recommendation)

_____

_____

Remedial Action Proposed:

_____

_____

Signature of Authorised Officer : _____

Name & Position : _____

Date : _____

SECTION 5. PERSONAL DATA PROTECTION NOTIFICATION

1. To process, administer and/or manage your relationship, account and policy with Raffles Health Insurance Pte. Ltd, its associated persons/ organisations and/ or its or their representatives, whether within Singapore or outside Singapore ("RHI") and its or their third party service providers, RHI will necessarily need to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes (i) information set out in this form and any other personal information provided by you or possessed by RHI.

2. Such personal data will be collected, used, disclosed and/or processed by RHI for the purpose(s) of :

   (a) to source for and objectively recommend the products to meet your insurance needs for your consideration;
   (b) considering whether to provide you with the insurance you applied for;
   (c) processing your application for underwriting and insurance;
   (d) administering and/or managing your relationship, account and/or policy with RHI;
   (e) processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under your policy;
   (f) carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by RHI;
   (g) carrying out your instructions or responding to any enquiries by you;
   (h) dealing in any matters relating to the services and/or products which you are entitled to under this policy which you are applying for or have applied; (including the mailing of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same as well as on the external cover of envelopes/mail packages);
   (i) investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned;
   (j) complying with applicable law in administering and managing your relationship with RHI; and/or
   (k) sending me marketing, advertising and promotional information about other insurance, investment and/or financial products and/or services that RHI may be selling or marketing, and which RHI believes may be of interest or benefit to me, by the following modes of communication :
      i. postal mail, electronic transmission to my email address, SMS/MMS (text message) and fax;
         ☐ *Please tick this box if you **do not** wish to receive communication via postal mail, email, SMS/MMS (text message) and fax.*
      ii. to my telephone number(s): _____ by way of :
         ☐ voice call (*Please tick this box if you do not wish to receive communication via voice calls)*

   (collectively the "**Purposes**")

3. We may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.

4. By signing on the Application Type of this form, you:

   (a) consent to RHI collecting, using, disclosing and/or processing your personal data for the Purposes as described above;

   (b) consent to RHI collecting personal data about you from sources other than yourself and using, disclosing and/or processing the same, for one or more of the Purposes as described above;

   (c) consent to RHI disclosing your personal data to its third party service providers, or agents (including its lawyers / law firms), for the Purposes as described above;

   (d) consent to RHI transferring your personal data out of Singapore to its third party service providers, or agents where such third party service providers or agents are sited (whether in Singapore or outside of Singapore), for the Purposes as described above; and

   (e) represent and warrant that you are the user and/or subscriber of the telephone number(s) provided by you in this form, and that you have read and understood the above provisions.

5. I/ We are aware that the RHI's Privacy Statement which serves to inform me/us of RHI practices on Personal Data management is available on its website, http://www.rafflesheathinsurance.com