

## **LIA Guidelines on Needs-based Sales Process For Individual Health Insurance Products**

### **OBJECTIVES & DESIRED OUTCOME**

The objective of these Guidelines is to set a minimum standard for the needs-based sales process for insurance representatives.

It is important for a representative to obtain relevant information on a client's health insurance needs, objectives and goals, and to put this information through proper analysis before making appropriate recommendations on product suitability.

The client would also need to understand the status of the representative in order to make an informed decision when considering the representative's recommendations.

### **SCOPE**

#### **Applicable**

The Guidelines apply to:

- **Health policies (including health insurance bundled with or rider to life policies) sold to individuals by insurance representatives i.e. life insurance agents, general insurance agents, brokers, and representatives of financial representatives, banks and financial institutions.**

Note: Separate advisory process guidelines are issued for Group health products, in recognition of the differences in the motivation for purchase, and the level of knowledge between that of an individual buyer and of a corporate buyer.

#### **Not Applicable**

The following requirements

- a) Disclosure of representative's status
- b) Use of fact find form
- c) Use of needs analysis/recommendation form

do not apply to:

- **Direct marketing (provided NO advice has been given)**

Includes Internet as a tool of DM, but not as an e-intermediary

- **Personal Accident Policy with or without Medical Reimbursement due to Accident only**
- **Hospital cash due to Accident only**
- **Eldershield, where advice is for a person who has previously opted out to re-opt into Eldershield**

## MINIMUM FACT FIND FORM AND NEEDS ANALYSIS & RECOMMENDATION FORM

### Minimum Industry Standard

The substantive contents and information contained in the forms (listed below) appended to the Guidelines must be adopted as a minimum industry standard:

Appendix 1A: "Know Your Client" Form (Individual Health policies)

Appendix 1B: "Our Advice and Reasons Why" Form

Note: Insurer may incorporate the Fact Find and Needs Analysis & Recommendation for life and health products into one form but **"Application type" is to be distinguished for life and health insurance.** Fact Find and Need Analysis & Recommendation pertaining to Health Insurance is also required when a health product that is bundled with or rider to life policies.

### Format

- The 'look and feel' and sequence of contents of the forms may be modified. For example, the section on "Application type" need not appear on the front cover of the fact find form.
- Substantive subject headings or categories may not be omitted.
- However, the wordings need not be adopted in verbatim fashion. For example, the titles of the forms, "Know Your Client" and "Our Advice and Reasons Why" need not be adopted in verbatim fashion.

### Application Type

For individual accident and health policies:

"Application type" in the fact find form is to be ticked and signed off as follows:

- (1) I/We have disclosed relevant information for comprehensive planning.**

Explanatory note: For full completion of fact find where client wishes to receive representative's recommendation on product suitability.

Fact find form is to be completed. Client has to acknowledge Application Type.

- (2) I/We have disclosed relevant information for specific need(s) planning.**

Explanatory note: For partial completion of fact find where client wishes to receive representative's recommendation on product suitability.

Fact find form is to be completed. Client has to acknowledge Application Type.

- (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.**

Explanatory note: It is mandatory to explain product features, fees and charges to the client.

Client has to acknowledge Application Type.

## Minimum requirements for each Application Type

Minimum requirements	Application Type		
	(1)	(2)	(3)
Personal information	√	√	√
Dependant	√ (w.a)	o	n.a
Existing health policies	√	o	n.a
Personal priorities	√ (w.a)	√ (w.a)	n.a
Health conditions	√	√	n.a
Replacement of policy	√	√	n.a
Needs analysis	√ (> 1 need)	√ (1 or > needs)	n.a
Recommendation	√	√	n.a
Client's choice of App. Type	√	√	√
Acknowledgement by client	√	√	√

√	compulsory
w.a	where applicable
o	good to have
n.a	not applicable

### RESPONSIBILITIES OF LIFE INSURER & PRINCIPAL OF LIFE INSURANCE REPRESENTATIVES & LIFE INSURANCE REPRESENTATIVE AND SUPERVISOR

#### Responsibilities of Life Insurer/Principal of Life Insurance Representatives/Supervisor of Representatives

- Insurer as the product provider needs to *keep a copy of the Fact Find Form* where the client specifically indicates his preference for advice or no advice (i.e. application type); and for a length of time according to individual companies' practice. Information kept must provide the necessary audit trail.
- The principal of the representative shall keep the Fact Find, Needs Analysis and Recommendation Forms for a length of time according to individual companies' practice. Information kept must provide the necessary audit trail.
- The principal must ensure that a register is set up and maintained by itself or its distribution entity (i.e. tied agencies, department(s) of bank/financial institution, or associate units of broking firm) for audits by the MAS.
- The format of the register for individual health is as follows:

Policy No.	Application date	Name of insured	Name of Representative	Application Type*	Supervisor agrees with Recommendations? (Y/N)	Remarks	Supervisor's signature/Date
B0015	14/09/2000	Tan Su Ling	Jane Lee	1			
L143562	14/09/2000	Moses Yeoh	K Nathan	2			
T2250	15/09/2000	Lynn Carter	K P Seow	3			

## Notes

- Numbered according to the 3 boxes under “Application type” in the fact find form.
- Supervisor of representative must sign off on register as soon as practicable.
- Intervention to rectify erroneous recommendation is to be taken before expiry of the free-look provision. Conflicts between representative and his supervisor should be resolved according to internal procedures.

### **Responsibilities of Life Insurance Representative**

- Representative has to ensure that his client and him sign off afresh together, with the current date appended, on the Fact Find, Reason Why and Recommendation Forms at each separate occasion of purchase. A copy of a Fact Find Form which was completed on an earlier occasion may be used, provided the information is still current.
- Representative has to ensure that client signs off on the “Our Advice and Reasons Why” Form (under “3. Acknowledgement”), if applicable, at the time of completion of the proposal form to indicate if the client agrees or disagrees to take up the representative's recommendation on product suitability.
- Representative is to provide the Fact Find, Needs Analysis and Recommendation Forms to the client as soon as practicable.
- Representative shall treat the information received from clients with confidentiality and should not disclose any information acquired from their clients without prior consent unless it is in relation to an insurance application and where there is a public duty or legal or professional obligation to disclose such information.

<b>MONITORING IMPLEMENTATION OF THE GUIDELINES</b>
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### **Responsibilities of the Insurance Representative and Supervisor**

- Representative is to ensure that he:
  - a) Completes the following areas in the Fact Find Form and Needs Analysis/Recommendation Form for all policies sold to individuals:
    - Application type
    - Representative's declaration
    - Representative's analysis and recommendation
    - Representative's acknowledgement
  - b) Submits the page of the Fact Find Form where the client specifically indicates his preference for advice or no advice (i.e. application type) together with the corresponding proposals to the insurer.
  - c) Provides a copy of the Fact Find, Needs Analysis and Recommendation Forms to the client/policyholder.
  - d) Submits a copy of the said Form to his supervisor for the latter's validation to be obtained as soon as practicable.
- Supervisor is to ensure that he:
  - a) If applicable to his organisational structure, sets up and maintains a Register for submissions of the said Forms by his representatives to be recorded therein.

- b) Validates the following fields in the Register records of the said Forms, submitted by his representatives:
- Application type
  - Supervisor agrees with Recommendation?
  - Remarks
  - Supervisor's signature/date
- c) Files copies of the said Forms and, if applicable, archives the validated Register records for purposes of compliance audited by the MAS.

### **Responsibilities of Life Insurer**

- a) Insurer is to ensure that it underwrites proposals submitted only if accompanied by the required form duly completed and signed.

### **Responsibilities of Principal of Life Insurance Representatives**

Principal of Life Insurance representatives has to:

- a) Ensure proper maintenance of its Register or, if applicable, monitor the representatives of its distribution entity for proper maintenance of their Registers, including proper and timely validations by supervisors.
- b) Take appropriate and timely actions to rectify an erroneous recommendation made to a policyholder.

### **REMEDIES FOR NON-COMPLIANCE BY LIFE INSURANCE REPRESENTATIVES**

- Representatives found not to have submitted duly completed and signed Fact Find Form and Needs Analysis/Recommendation Form to the insurer for underwriting, or to the client, or to the supervisor will be penalised as follows:
  - 1<sup>st</sup> offence – counseling
  - 2<sup>nd</sup> offence – re-training on HI
  - 3<sup>rd</sup> offence – letter of warning
  - 4<sup>th</sup> offence – three months suspension
  - 5<sup>th</sup> offence – termination of contract
- Insurer is to ensure that supervisors validated the Recommendation Form (i.e. Register record) submitted by their representatives as soon as practicable and take appropriate and timely actions to rectify an erroneous recommendation made by their representatives.

### **EFFECTIVE DATE**

The Guidelines came into effect from 1 April 2004.

1<sup>st</sup> update: May 2005

2<sup>nd</sup> update: May 2012 (in yellow highlights)

3<sup>rd</sup> update: July 2023 (in green highlights)

LOGO OF INSURER (EXEMPT FA) / OTHER EXEMPT FA / FA / IFA

“Know Your Client” Form  
**Confidential Fact Find for**  
e.g. Ms Tan Siew Lee  
BY  
e.g. Alex Lim Boon Howe

**Important Notice to Clients**

**Disclosure of status of representative:**

Your insurance representative is with (name of company) and can advise you on the products of (name of company)

OR

Your insurance representative is with (name of company). Your 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 sources the products.

**Standard statement applicable to all representatives:**

Your 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 or following partial or inaccurate completion may not be appropriate to your needs.

**Application type**

**Client’s choice**

1.  I/We have disclosed relevant information for comprehensive planning.
2.  I/We have disclosed relevant information for specific need(s) planning.
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.

Signature of client:  
Date:

Signature of client:  
Date:

Signature of representative:  
Date:

**1 PERSONAL INFORMATION**

**1a. Personal Details of Client**

Name: Mr/Mrs/Miss/Ms/Dr \_\_\_\_\_

NRIC/ Passport No.: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

Marital Status: Single / Married / Divorced / Separated / Widowed Gender: M/ F

Email Address: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**1b. Employment Details**

Current Occupation \_\_\_\_\_ Monthly Income Range

1.  Below \$2,500  
 2.  \$2,501 to \$5,000  
 3.  \$5001 & above

**1c. Details of Spouse & Dependants (If family coverage is required)**

Name / Relationship	DOB	Gender	Occupation	Monthly Income Range (see Question 1b above)		
_____	____ / ____ / ____	M/F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	____ / ____ / ____	M/F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	____ / ____ / ____	M/F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____	____ / ____ / ____	M/F	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

**2 EXISTING HEALTH INSURANCE POLICIES**

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

Policy Type*	Insured**	Type & Amount of Benefit++	Annual Premium++	Expiry Date++
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

\* Individual or Group policy from employer

\*\* Y = You; S = Spouse; J = Joint

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

**3 PERSONAL PRIORITIES**

**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, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for dental expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for old age disabilities	<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"/>

**4 HEALTH CONDITION**

Do you or any applicants have any medical condition which requires you **or the applicants** to receive regular attention from a doctor in a clinic or hospital?  Yes  No

If 'Yes', what is/are these medical condition(s)?

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**5 REPLACEMENT OF POLICY**

Do you intend to replace any existing health insurance policy? **Yes / No**  
(If yes, Representative should state the reasons for replacement in the "Statement by Representative" section)

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**6 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**

**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: \_\_\_\_\_

LOGO OF INSURER (EXEMPT FA) / OTHER EXEMPT FA / FA / IFA

**“Our Advice and Reasons Why”**

for

e.g. Ms Tan Siew Lee

BY

e.g. Alex Lim Boon Howe

<b>Statement by Representative</b>
<p>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 knowledge. If there has been any change in your circumstances since completing that 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.</p>

## 1. Analysis and calculation worksheet

### 1.1 Disability income benefit

Type of disability: \_\_\_\_\_

	Client	Spouse	Child
a. Total monthly expenses to be covered	_____	_____	_____
b. No. of months expenses to be covered	_____	_____	_____
c. Total amount of expenses to be covered (a*b)	_____	_____	_____
d. Existing annual disability benefit covered	_____	_____	_____
e. No. of years benefit payable	_____	_____	_____
f. Existing total disability benefit (d*e)	_____	_____	_____
<b>Total amount of disability benefit needed (c-f)</b>	_____	_____	_____

### 1.2 Hospitalisation Expenses

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)	_____	_____	_____

### 1.3 Critical Illnesses Benefit

a. Total lump sum benefit to be covered	_____	_____
b. Existing lump sum benefit covered	_____	_____
<b>Estimated lump sum benefit needed (a-b)</b>	_____	_____

## 2. Representative analysis and recommendations

Total health insurance budget (if available): \_\_\_\_\_ per month/per annum

Representative's recommendations	Reasons for recommendations	Remarks
<input type="checkbox"/> Disability income benefit		Replacement policy: Y/N
<input type="checkbox"/> Hospitalisation expenses		Replacement policy: Y/N Medical Insurance for migrant worker: Y/N
<input type="checkbox"/> Critical illnesses benefit		Replacement policy: Y/N

**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 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

**(\*Delete as appropriate.)**

Signature of client:

Date:

Signature of client:

Date:

Signature of representative:

Date:

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**Note:**

**The substantive contents and information contained in this form must be adopted as minimum industry standard. Substantive subject headings or categories may not be omitted but the wordings and contents may be modified as deemed relevant to the recommended products.**

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