INSURANCE COMPANY	
BROKER NAME	
POLICY NUMBER	
INSURER NO./CODE	
BROKER NO./CODE	

KNOW-YOUR-CUSTOMER (KYC) DUE DILIGENCE CHECKLIST COMPANY/ PARTNERSHIP/SOLE TRADER (Institutions)

The purpose of this checklist is to ensure that the identity of the Policy Owner and their source of funds are properly verified in order to achieve compliance with. Anti-Money Laundering Legislation (Section 15 (Customer Identification) of the Money laundering (Prevention) Act No.8 of 2010 of St Lucia), Regulations and Guidelines.

The checklist must be completed and submitted as a part of every application for insurance whether it is an individual or a legal entity such as a company or partnership.

Original documents only must be used in the verification process and must be copied and attached to this form.

The checklist must be completed by the Underwriter and reviewed and evaluated by the Supervisor.

This form must be signed off by the AML Compliance Officer if the annual premium on a policy is equal to or in excess of EC$75,000.00

In accordance with Section 21 of the Money Laundering (Prevention) Act No.8 of 2010 of Saint Lucia, a Source of Fund Declaration must be accompany any transaction which exceeds EC$25,000.00

Please tick the appropriate boxes and attach supporting documents where applicable.

POLICY OWNER NEW CLIENT ☐ EXISTING CLIENT ☐

REGISTERED NAME OF BUSINESS:				
IF SOLE TRADER NAME OF INDIVIDUAL:				
ADDRESS OF REGISTERED OFFICE:			COUNTRY:	
TRADING NAME (if applicable):				
TRADING ADDRESS:				
MAILING ADDRESS:				
TELEPHONE NO.: Work:		Mobile:	Fax:	
Email Address:				
POLICY OWNER TYPR:	COMPANY ☐	PARTNERSHIP ☐	Sole Proprietorship ☐	charitable entity ☐
OTHER UNINCORPORATED ENTITY(specify) ☐				
COMPANY TYPE:	PUBLIC ☐	PRIVATE ☐	OWNER MANAGED ☐	
DATE OF COMMENCEMENT OF BUSINESS:		COUNTRY:		
DATE OF INCORPORATION:		PLACE OF INCORPORATION:		
COMPANY REGISTRATION NUMBER:				

Section (A) Verification of Identity of Policy Owner

1. Company		
DOCUMENT TYPE	**DATE CERTIFIED BY REGISTRAR/ ANNUAL RETURN DD/MM/YYYY**	**Doc attached?**
DOCUMENT OF INCORPORATION		Yes: ☐ No: ☐
MANAGEMENT ACCOUNTS		Yes: ☐ No: ☐

ANNUAL RETURN ☐ OR LIST OF DIRECTORS AND SHAREHOLDERS ☐		Yes: ☐ No: ☐
2. PARTNERSHIP		
DOCUMENT TYPE (attach copies)	**Date Notarized/ Authorization dd/mm/yy**	**Documents attached?**
Copy of Partnership Agreement		YES ☐ NO ☐
List of authorized signatories for this transaction		YES ☐ NO ☐
List of current Partners (address and identification number to be included)		YES ☐ NO ☐

SECTION (B) BUSINESS ACTIVITIES OF POLICY HOLDER

Type of business (please select box and specify for items marked with an asterisk *	
*Financial Service ☐ *Import/Export: ☐ Dentist/Doctor: ☐ Attorney: ☐ *Distribution ☐ *Retail ☐ Construction ☐	
*Real Estate ☐ Accountant ☐ *Retail ☐ Transport/Travel Agent ☐ Other (specify) ☐	

Section (c) Verification of source of funds (SOF)

Has the Declaration of Source of Funds Form been completed?	**YES** ☐	**NO** ☐	**N/A** ☐

Section (D) Additional Information (please provide any additional information that may be useful in processing this application).

Declaration:

I hereby declare that details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Insured's Signature: ______________________ **Date:** ______________________

FOR OFFICIAL USE ONLY		
I CONFIRM THAT ALL THE REQUIRED DOCUMENTS WERE VERIFIED AS BEING TRUE COPIES OF THE ORIGINALS		
If applicable, was senior management approval obtained on SOF for politically exposed person? YES ☐ NO ☐ N/A ☐		
Name:	Signature:	Date (dd/mm/yy)

Reviewed by:	Approved by: AML Compliance Officer (for applications where annual premium payments are equal to or exceeds EC$75,000.00)
Name:	Name:
Title:	Title:
Signature:	Signature:
Date: (dd/mm/yy)	Date: (dd/mm/yy)