

**TOTAL AND PERMANENT DISABILITY CLAIM FORM**  
(Income Family MicroInsurance Scheme)

Dear Claimant

We are sorry to learn of your injury. In order for us to process your claim, please complete this form in FULL and attach the following documents:

**Important Notes:**

**The acceptance of this form is NOT an admission of liability on the part of NTUC Income.**

- (a) Please submit the duly completed claim form together with the supporting documents within 6 months from date of occurrence. Claims submitted after this deadline will not be accepted.
- (b) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible. For each of the document listed below, please tick (✓) where applicable. Where not applicable, please indicate as 'N.A.'
- (c) If you need any assistance, please contact our Customer Service Officers at **6788 1122** or email us at **csquery@income.com.sg**.

<input type="checkbox"/> Total and Permanent Disability Claim Form
<input type="checkbox"/> NRIC(s)/Passport(s) of Claimant
<input type="checkbox"/> Attending Physician's Statement (APS) (to be completed by attending physician and submitted to us)
<input type="checkbox"/> Medical Reports/Hospital Discharge Summary/Doctor's memos/Medically boarded out letter (if available)
Claim No. (for official use only)

**Particulars of Claimant**

Name (as shown in NRIC)		NRIC No.
Address		
Contact No. (H) (0) (HP)	Email	
Is the Claimant an undischarged bankrupt? If yes, please provide the bankruptcy number, name and contact details of the case officer representing the Official Assignee.		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Details of Disability**

Cause of Disability	Date of Disability (dd/mm/yyyy)
Description of Disability	
Is there loss of sight? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there loss of limbs? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which are the Activities of Daily Living (ADL) that you now cannot perform independently? - feeding, mobility, transferring, washing/bathing, dressing, and toileting/continence	

**Particulars of Alternative Contact Person (If Any)**

Name (as shown in NRIC)		NRIC No.
Address		Email
Contact No. (H) (0) (HP)	Relationship to Claimant	

GH/MCYS-TPD/04/2010

### Details of Past Related Claims (If Any)

Have you, your spouse, parents, children, brothers or sisters made a claim under the Income Family MicroInsurance Scheme previously? If "Yes", please provide details of such claim below. Please note that each Insured's (under the Income Family MicroInsurance Scheme) family unit is not allowed to submit more than 1 claim per calendar year. Any claim submitted in breach of this will be rejected.

Yes  No

### Declaration

1. I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income.
  2. I agree and authorise:
    - (a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and
    - (b) NTUC Income to release any relevant information concerning me to any medical institution or medical practitioner, or insurer or organisation or person.
- A photocopy of this form is valid as an original copy.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date (dd/mm/yyyy)