

Enhanced Welfare Insurance Scheme Hospitalisation Benefit Claim Form

Dear Claimant

In order for us to assess your claim, please submit the completed claim form and the required documents through the member's respective union (for Ordinary Branch) or NTUC Membership Dept (for General Branch/U Club/UAssociate).

Important notes

- (a) All items must be duly completed to avoid delay to the claim process. Please indicate as "N.A." if not applicable.
- (b) Upon receipt of ALL the required documents, we will assess your claim and inform you of the outcome as soon as possible. Please allow approximately 4 - 6 weeks for claim assessment, subject to submission of all required documents.
- (c) The acceptance of this form is NOT an admission of liability on the part of Income Insurance. Any documentary proof or report required by Income Insurance shall be furnished at the expense of the Claimant. To avoid delay to the claim process, please submit the duly completed claim form together with the supporting documents **within 90 days from date of occurrence**.
- (d) If your contact particulars (i.e. address, contact number and email) indicated in this form are different from your existing records with us, we will not update all your existing policies with the new contact particulars.

Information on member

Full Name of member (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing address	Nationality	Country of residence
Contact number (Mobile) (Office) (Home)	Email	

Information on insured person

Insured person is: <input type="checkbox"/> Member <input type="checkbox"/> Member's Spouse			
Full Name of insured person (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Nationality	Country of residence

Details of the claim

1. Details of the claim

a. Type of visit	b. Date of visit	c. Details of treatment(s) received

Medical Condition

2. Details of illness or injury

a. Illness or injury	b. Describe symptoms	c. Date the symptoms started (dd/mm/yyyy)
g. Name and address of <u>referring</u> General Practitioner or Clinic		h. Name and address of <u>regular</u> General Practitioner or Clinic

3. Please complete the following if the treatment is for injury sustained as a result of an accident		
a. Date and time of accident (dd/mm/yyyy)	b. Place of accident	c. Is it Work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Give details of the accident and how the injury was caused by the accident. (Please enclose a copy of the police report, if any.)		
e. Are these medical expenses claimable under your company's Work Injury Compensation Act Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Other information

4. Have you claimed or do you intend to claim from any insurer, other employer or any other parties for reimbursement of your medical bills? If 'Yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover if there is any excess amount paid to you.</p>	

Payee's details

Name of payee (as shown in the bank account)	NRIC, FIN, Passport or UEN number (as shown in the bank account)	Nationality	Country of residence
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Payments will be credited in SGD directly to Payee's PayNow account linked to NRIC/FIN/UEN. You may register or add your Singapore NRIC/FIN to the PayNow account via the "Manage PayNow" in your internet banking or mobile banking application if you have not done so.

Alternatively, please submit a copy of your bank book/statement showing the name of bank, account holder name and account number if you prefer payment via direct credit.

Personal data use statement (A photocopy of this authorisation is valid as an original copy)

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income Insurance"), its representatives, agents, relevant third parties, Income Insurance's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Insurance Parties") (referred to in Income Insurance's Privacy Policy at <http://www.income.com.sg/privacy-policy>) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income Insurance including sending me/us corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in Income Insurance's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Insurance Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income Insurance, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

- The medical source, insurance office, reinsurer, or organisation to release to Income Insurance any medical or relevant information to do with me or the insured;
- Income Insurance to collect from and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the insured; and
- Income Insurance or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income Insurance to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income Insurance.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income Insurance to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Insurance Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income Insurance's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Insurance Parties for all the relevant purposes listed above and in Income Insurance's Privacy Policy.

Please refer to Income Insurance's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

Declaration and authorisation

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the 'Personal Data Use Statement'(PDUS) above.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income Insurance is to insure or continue to insure me for my insurance applications or policies,

- I authorise any person or organisation who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income Insurance and/or its claims service providers.
- I authorise Income Insurance and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).
- I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I confirm that all documents submitted to Income Insurance including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income Insurance when required. I am aware that Income Insurance may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income Insurance for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income Insurance will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income Insurance will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income Insurance has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income Insurance has the right to recover any payment made by Income Insurance to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name of employee/member

Signature of employee/member

Date (dd/mm/yyyy)

Name of patient
(if different from the
employee/member)

Signature of patient
(To be signed by patient's parent or legal guardian
if patient is below 21 years old)

Date (dd/mm/yyyy)

To be completed by employer/union

Name of employer/union

Policy number

Effective date of patient's insurance/member's date joined union (dd/mm/yyyy)

Plan type

Name of authorised personnel

Signature and company's/union's stamp

Date (dd/mm/yyyy)