income made yours

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30-day Protect Data Plan Free Cover claim form

Important notice

- If we accept this form, this does not mean we are taking legal responsibility for your claim.
- If we ask for any documents as proof or a report, you will have to pay the costs involved in providing it.
- To avoid delay in processing your claim, please send your completed claim form, together with the supporting documents, within 30 days from the date of the event.
- Please do not leave any answer blank. Write 'none' or 'NA' where relevant.

Policy number:	
Claim number: (For official use)	

Personal details of policyholder

Name of policyholder (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
Contact number (Office) (Home) (Handphone)	Email	
Note: For death claim, to fill in the details of the person filing the claim under the policyholder.		

Personal details of insured (Do not fill this in if it is the same as above)

Full name (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
Contact number (Office) (Home) (Handphone)	Email	

Payee's details

Please tick √ the claim payment mode.

☐ For payment by direct transfer into **Policyholder's bank account**. Please provide supporting documents such as bank statement for verification of payee details.

Full name (as shown in the bank account)	Nationality	Name of Bank	Bank Account Number

☐ For payment by PayNow (registered with **NRIC No. only**)

Details of incident, injury or illness

Date of incident (dd/mm/yyyy)	Time of incident ☐ am ☐ pm	Place of incident
Say what happened		
Nature and extent of injury or illness sustained		

1. Has the insured person previously suffered a similar injury or illness? ☐ Yes ☐ No
   If Yes, please give details.

2. How long was the hospital stay?

Supporting documents

(A) If you are claiming for **Accidental death**, please send to us the following.

1. A copy of the death certificate
2. The autopsy report, toxicological report and coroner's findings
3. Proof of your relationship with the person who died

Policyholder or person claiming	Documents needed
Husband or wife	Marriage certificate
Parent	Birth certificate of person who has died
Child	Birth certificate of policyholder or person claiming
Brother or sister	Birth certificate of person who has died and policyholder or person claiming

4. Newspaper clipping and police or accident report
5. Last will of the person who died (if they left a will) or letter of administration (if there is no will)

(B) If you are claiming for **Permanent disability**, please send to us the following.

1. Inpatient discharge summary (if you have to stay in hospital)
2. Newspaper clipping and police or accident report
3. A filled-in medical report (see 4th page of the claim form)

(C) If you are claiming for **Daily hospital income after more than 4 days of hospitalisation due to an accident**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary (if you have to stay in hospital)
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(D) If you are claiming for **Get well benefit after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(E) If you are claiming for **Job loss after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)
5. Letter from employer stating the reason of termination is due to no longer medically fit to perform the major duties connect with your employment

This is not a full list and we may ask for other documents.

Personal Data Use Statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties (referred to in Income's Privacy Policy at https://www.income.com.sg/privacy-policy), Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income including providing me/us with financial advice/ financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income, its affiliates, business partners and/ or NTUC Enterprise group of social enterprises ("NE Group") where required for Income, its affiliates, business partners and/or NE Group, to develop, improve and/ or customise their products/ services and/ or to provide you with their respective products /services, and in the manner and for other purposes described in Income's Privacy Policy.

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

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorization and approval on their behalf for the purposes as set out in this Personal Data Use Statement.

Please refer to Income's Privacy Policy (https://www.income.com.sg/privacy-policy) for more information, including access and correction to personal data and consent withdrawal.

Declaration and authorisation

I/We cannot alter any of the wordings in this claim form. Any attempt to do so will have no effect.

I/We declare that the answers given in this form are true, correct and complete. I/We accept full responsibility for them, whether written by me/us or by anyone else on my/our behalf. I/We have not withheld any information. If it is discovered later that the insured suffers from a medical condition that is not disclosed in this form, I/we will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income.

I/We confirm that I/we understand and agree to the collection, use and disclosure of my/our personal data as stated in the "Personal Data Use Statement" (PDUS) above. I/We further confirm on the representation and warranty made in the PDUS.

If this claim is submitted under a group policy,

a. I, the insured, consent to (1) the group policyholder disclosing to Income; and (2) Income disclosing to the group policyholder, my personal data (including claims information and outcome) for the purposes of claims administration;
b. We, the group policyholder represent and warrant that we have obtained the consent from the insured (1) to disclose to Income the insured's personal data (including claims information and outcome); (2) for Income to disclose the insured's personal data including all claims information and outcome to the group policyholder to facilitate the administration of the claims that we have submitted in this form, where necessary.

For the purpose of administering and processing my/our claim, I/we authorise, consent and agree to:

a. The medical source, insurance office, reinsurer, organisation to release to Income any medical or relevant information to do with me/us or the insured;
b. Income and its relevant third parties stated in Income's Privacy Policy to collect from, use and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me/us or the insured; and
c. Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to assess this claim.

I/We confirm that all copies of the claim documents that I/we have submitted to Income are copies of the original documents and I/we agree to retain all original documents for a period of 6 months from claim submission date for Income to verify its authenticity.

I am/We are aware that Income may reject any claim if any copy submitted is not a copy of the original document and may recover any payment made to me/us.

I/We confirm that I/we have paid in full all the bill(s)/invoice(s) that I/we have submitted to Income for reimbursement and I/we have not made nor will I/we make any claim against any other source for the same bill(s)/invoice(s).

If I/we have made a claim from other source, a. I/we agree that I/we will provide a copy of any document requested by Income of the payment received by me/us; b. I am/we are aware that Income will not reimburse me/us if I/we have been fully reimbursed by such source; c. I am/we are aware that Income may only reimburse me/us up to the remaining balance of the unpaid bill/invoice I/we have been partially reimbursed by such source; d. I/we undertake to refund on demand any payment made by Income to me/us which exceeds what I/we have incurred in total.

I/We understand that I/we must give Income all documents, authorisations or information required by Income to assess the claim. If I/we fail to co-operate with Income in administering and processing the claim, I am/we are aware that the assessment of the claim may be delayed or Income may reject the claim.

I/We agree that this form may be signed by electronic or digital signature, whether encrypted or not, which will be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Electronic signature may include electronically scanned and transmitted versions (e.g. via pdf) of an original signature.

Name of policyholder: ______________________

Signature: ______________________

Date (dd/mm/yyyy) : ______________________

Name of insured: ______________________

Signature: ______________________

Date (dd/mm/yyyy) : ______________________

Claim submission instruction

You may email the completed claim form and supporting documents to plineclaims@income.com.sg. Please be reminded to keep the original copy of the supporting documents for 6 months as we may request for them on case by case basis prior to settlement of the claim.

Medical report

The doctor must fill this in.
(You will have to pay any costs involved in the doctor providing this report.)

Name of Patient	NRIC number

1. Final diagnosis

2. Date of diagnosis (dd/mm/yyyy)

3. Nature of injury or condition and the extent of the injury

4. Was the condition caused by an accident? ☐ Yes ☐ No

   a) If Yes, please give the date of the accident (dd/mm/yyyy): ______________ Time of accident: ______________ AM/ PM

   Describe the accident

   ____

   b) If No, please state the cause of condition:

   ____

5. Was any surgery carried out for this condition? ☐ Yes ☐ No
   If Yes, please provide nature of treatment/name(s) of surgical procedure(s), surgical code & table.

6. Was the insured under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No
   If Yes, please state the blood alcohol content or type of drug and the quantity consumed.

7. Is the Insured's condition self-inflicted or as a result of attempted suicide? If Yes, please provide details. ☐ Yes ☐ No

8. Is the injury likely to cause loss of use of the injured part? ☐ Yes ☐ No

9. Is the loss likely to be permanent? ☐ Yes ☐ No
   If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.

For illness (if this applies)

1. Date of symptom first started (dd/mm/yyyy)	2. When did the patient first consult you about this condition?

3. Details of present symptoms, nature and date of treatment given

4. What were the underlying conditions? Please provide date of diagnosis

5. Doctors previously consulted by the patient for the above condition:

Name of doctor	Date of consultation	Name of clinic or hospital	Address

6. Has the patient fully recovered from the condition? If No, what follow up treatment are needed?

______________________________ ______________________________
Signature of doctor Date (dd/mm/yyyy)

______________________________ ______________________________
Name and position Name and address of clinic or hospital