

Details of disability

Disability suffered due to:

Illness

Diagnosis _____ Date symptoms started _____ (dd/mm/yyyy)

Accident

Date of accident _____ (dd/mm/yyyy) Time of accident _____

Place of accident _____

Detailed description of accident (How did the accident occur?)

Current Employment status Employed Unemployed

Date last worked (dd/mm/yyyy)

The insured is currently confined to

bed house hospital N.A.

Date insured returned or expect to return to work (dd/mm/yyyy)

Describe in detail the disability suffered

Details of doctor(s) consulted or hospital admission(s) for this disability

Name of doctor	Name and address of clinic or hospital	Date(s) of consultation (dd/mm/yyyy)	Date(s) of admission (dd/mm/yyyy)

Details of your regular or company doctor or any other doctor(s) consulted for any other medical conditions

Name of doctor	Name and address of clinic or hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other claims

Are you claiming from any other insurance company(ies) or other sources (employer, other medical insurances, Work Injury Compensation Act) in respect of this condition or injury? If "Yes", please provide the following information.

Yes No

Name of employer, insurance company etc.	Policy number	Date of issue	Type of plan	Claim amount	Claim notified (Yes or no)	Claim paid (Yes or no)

Other information

Has the claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy? If "Yes", please provide details.

Policyholder Yes No Details: _____

Assignee Yes No Details: _____

Donee/
Court Appointed Deputy Yes No Details: _____

Insured Yes No Details: _____

Payment method

Payment methods

PayNow by Insured Person's NRIC

Direct credit into insured Person's personal bank account

Name of bank: _____ Branch: _____

Account number: _____

(Please submit a copy of bank statement OR bank passbook showing account holder's name and account details. This must be a Singapore bank account denominated in Singapore Dollar that belongs to the Insured Person.)

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"), its representatives, agents, relevant third parties, Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") (referred to in Income'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, 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 my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income 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, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

- a) The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured;
- b) Income 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
- c) Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income 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.

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 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 Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income'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 Parties for all the relevant purposes listed above and in Income's Privacy Policy.

Please refer to Income'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 is to insure or continue to insure me for my insurance applications or policies,

- a. 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 and/or its claims service providers.
- b. I authorise Income 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).
- c. 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 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 when required. I am aware that Income 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 agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Full name and signature/thumbprint of Insured Person		NRIC/FIN/Passport	Date signed (dd/mm/yyyy)
Full name and signature of claimant who is 21 years old or above (if the Insured Person does not have mental capacity)	Relationship to Insured Person	NRIC/FIN/Passport	Date signed (dd/mm/yyyy)

Please indicate why Insured Person is unable to sign

Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Name of Insured (as shown in NRIC)		NRIC number
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number
<p>Declaration and Authorisation</p> <p>1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.</p> <p>2. I agree and authorise:</p> <p style="margin-left: 20px;">(a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and</p> <p style="margin-left: 20px;">(b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.</p> <p>A photocopy of this form is valid as an original copy.</p>		
_____ Signature/Thumbprint of Insured/next-of-kin ¹		_____ Date (dd/mm/yyyy)

¹ Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)		NRIC number
Height of Insured _____ m Weight of Insured _____ kg The above readings were taken on this date (dd/mm/yyyy) _____ / _____ / _____		
1. (a) Are you the Insured's usual doctor?		<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Over what period do your records extend? Start date (dd/mm/yyyy) _____ / _____ / _____ End date (dd/mm/yyyy) _____ / _____ / _____		
2. What is the diagnosis for the Insured's present illness/injury?		
(a) What is the exact date of diagnosis? (dd/mm/yyyy) _____ / _____ / _____		
(b) Please provide us the name and address of the doctor where the diagnosis was first made.		
(c) Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. (a) Was the condition caused by an accident? If "Yes", please state: Accident date (dd/mm/yyyy) _____ / _____ / _____ Accident time _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Describe the accident.		

Part 2 (To be completed by Doctor) (continued)

(c) Was the accident reported to the police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? If "Yes", please provide details.

Yes No

Name of referring doctor	Name and address of clinic/hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the referral

6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details.

Yes No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. (a) Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy, etc.).

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

Part 2 (To be completed by Doctor) (continued)

(b) Has the Insured been compliant with the treatment suggested? If "No", please provide details.		<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Are there plans for other forms of treatment? If "Yes", please provide full details.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment
(d) Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following:		<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Type(s) of treatment that would improve Insured's condition		
(ii) How would the treatment improve Insured's condition and to what extent?		
(iii) Why did Insured reject the treatment?		
9. What is the prognosis of the Insured's condition? <input type="checkbox"/> Improve <input type="checkbox"/> Deteriorate <input type="checkbox"/> Remain unchanged		
(a) Please describe the nature and severity of the Insured's condition.		
(b) Is full recovery expected? If "Yes", please state approximate date (dd/mm/yyyy) _____ / _____ / _____ If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). Date of last assessment (dd/mm/yyyy) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Range and strength (please indicate power grading of limbs)		
(ii) Gait and balance		
(iii) Coordination		

Part 2 (To be completed by Doctor) (continued)

(iv) Movement

(d) Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual?
If "Yes", please provide details.

Yes No

10. (a) Please tick as applicable in relation to the Insured's ability to perform the Activities of Daily Living, whether aided with special equipment or unaided.

Activity	Need someone to help throughout the entire activity	Period which help was required	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dressing Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical appliances.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Feeding Ability to feed oneself once food has been prepared and made available.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Toileting Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Transferring Ability to move from a bed to an upright chair or wheelchair and vice versa.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mobility Ability to move indoors from room to room on level surfaces.	<input type="checkbox"/> Yes <input type="checkbox"/> No		

(b) Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention?
If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).

Yes No

11. What was the Insured's occupation before his disability?

(a) What was the nature of his duties?

(b) Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why.

Yes No

12. (a) Has the Insured returned to his usual occupation?

Yes No

(b) If "No", would the Insured be able to return to his usual occupation at a later date?

- Not able to determine presently (Go straight to Question 14)
- Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) _____ / _____ / _____
- No – Not possible to return to usual occupation even at a later date

Part 2 (To be completed by Doctor) (continued)

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider in the future?

Yes Examples of such occupation(s) are: _____
 Expected date when his condition allows him to engage in these occupation(s) is:
 (dd/mm/yyyy) _____ / _____ / _____

No The Insured is unable to take part in any paid work for the rest of his life.
 Please provide us with reason (s) for your answer.
 Reason (s):

Please state the date when the Insured was considered not able to take part in any paid work for the rest of his life.

(dd/mm/yyyy) _____ / _____ / _____

14. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) _____ / _____ / _____

15. Please tick (✓) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

(a) Total and permanent loss of sight
 The loss must be permanent and irreversible, even with the use of visual aids.

Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

Part 2 (To be completed by Doctor) (continued)

(b) Severance of limbs/total loss of use of limbs

Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severance at or above elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Others (please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe the nature and cause of severance.

Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severance at or above knee	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Others (please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe the nature and cause of severance.

Total loss of use (defined as total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

Part 2 (To be completed by Doctor) (continued)

16. (a) Please describe the Insured's mental and cognitive abilities.

(b) Is the Insured mentally incapacitated in accordance to the Mental Capacity Act?

Yes No

(c) If "Yes" to Question 16b above, please state the date when the mental incapacity started.

Date of last assessment (dd/mm/yyyy) _____ / _____ / _____

17. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details.

Yes No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

18. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation.

Yes No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ / _____ / _____

19. Please provide us with any other information that will be helpful in the assessment of this claim.

<p align="center">_____ Signature of doctor</p>	<p align="center">_____ Date (dd/mm/yyyy)</p>
<p align="center">_____ Name and qualification (printed)</p>	<p align="center">_____ Address and official stamp of clinic/hospital</p>