NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

CancerAssist claim form

Important notice

- If we accept this form, it 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 them.
- 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 (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)
Home address		Occupation	Nationality
Contact number (Office) (Home) (Handphone)		Email	

Personal details of insured (No need to fill this in if the information is the same as above.)

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport 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**)

Claim details

1 Details of illness

a. Diagnosis _____

b. Date symptoms started (dd/mm/yyyy) _____

c. Describe in detail all symptoms and nature of medical condition suffered.

_____

2 Please provide the name, contact number and address of the doctor who is treating you for your current condition.

3 Was any surgery carried out for this condition? If Yes, please provide details below. ☐ Yes ☐ No

Surgical operation or procedure	**Date of operation or procedure** (dd/mm/yyyy)	**Surgical code or table** (please ask your doctor)

4 Has the insured person previously suffered a similar condition? If Yes, please give details. ☐ Yes ☐ No

Supporting documents

The below documents which have been **marked** will be enclosed with the claim form.

☐ 1 Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor & submitted to us)

☐ 2 Medical reports/Laboratory reports/Hospital Discharge Summary

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 NTUC Income Insurance Co-operative 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, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income 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'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 confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income 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 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 will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income 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 has the right to recover any payment made by Income to me.

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

Name of policyholder: _____ Name of insured: _____

Signature: _____ Signature: _____

Date (dd/mm/yyyy) : _____ 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.

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Attending Medical Practitioner's Statement Cancer/Major Cancers

Part 1 (to be completed by the insured)

Policy number	Plan type	Claim number

Name of insured (as shown in NRIC)	NRIC number

Address of Insured

Name of next-of-kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number

Address of next-of-kin

Authorisation
I agree and authorise:
(a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to Income any information as requested by Income; and
(b) Income to release any relevant information concerning me/my child 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/Thumbprint of insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Part 2 (to be completed by the doctor)

Name of insured (as shown in NRIC)	NRIC number

A. General information

1. (a) Are you the Insured's usual doctor? ☐ Yes ☐ No

(b) Over what period do your records extend?

Start Date (dd/mm/yyyy) _____ /_____ /_____ End Date (dd/mm/yyyy) _____ /_____ /_____

2. When did the Insured first consult you for this condition? (dd/mm/yyyy): _____ /_____ /_____

3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.

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

What / who is the source of this information?

Part 2 (to be completed by the doctor) (continued)

4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? If "Yes", please provide details.	☐ Yes ☐ No

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

B. Details of dread disease

5. (a) What is the histological diagnosis of the disease?

(b) Date of diagnosis (dd/mm/yyyy): _____ /_____ /_____

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

(d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy): _____ /_____ /_____

6. (a) Was a biopsy of the tumour performed? If "Yes", please state the date of biopsy (dd/mm/yyyy): _____ /_____ /_____ If "No", please state why and how the diagnosis was confirmed.	☐ Yes ☐ No

(b) What was the site or organ involved?

(c) What is the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM Classification, etc.).

i. Has the cancer spread beyond the layer of cells in which it began?	☐ Yes ☐ No
ii. Was the disease completely localised?	☐ Yes ☐ No
iii. Was there invasion of adjacent tissues?	☐ Yes ☐ No
iv. Were regional lymph nodes involved?	☐ Yes ☐ No
v. Were there distant metastases? If "Yes", please provide full details, including site of any metastases, etc.	☐ Yes ☐ No
7. Is the condition carcinoma-in-situ?	☐ Yes ☐ No
8. Is the condition pre-malignant or non-invasive?	☐ Yes ☐ No
9. Is the condition having borderline malignancy or is suspicious of malignancy only?	☐ Yes ☐ No
10. Is the condition Cervical Dysplasia CIN 1, CIN 2, CIN 3 (severe dysplasia without Carcinoma-in-situ)?	☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

11. Is the condition Carcinoma-in-situ of the Biliary system?	☐ Yes ☐ No
12. Is the condition Hyperkeratoses, basal cell and squamous skin cancers?	☐ Yes ☐ No
13. (a) Is the condition Bladder Cancer described as TNM classification T1N0M0 or below?	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Bladder?	☐ Yes ☐ No
14. Is the condition Prostate cancer described as TNM classification T1N0M0, T1 or another equivalent or lesser classification? If yes, please circle: T1a / T1b / T1c	☐ Yes ☐ No
15. (a) Is the condition Thyroid Cancer described as TNM classification T1N0M0 or below? If "Yes", please state the size in diameter _____ cm	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Thyroid? If "Yes", please state the size in diameter _____ cm	☐ Yes ☐ No

16. If the diagnosis is leukaemia, please state:

(a) Type of leukaemia _____

(b) RAI staging _____

17. If the diagnosis is malignant melanoma, please give full details below:

(a) Size, Thickness (Breslow classification) (mm) _____

(b) Depth of invasion (Clark level) _____

(c) Has the condition caused invasion beyond the epidermis?	☐ Yes ☐ No

18. If the diagnosis is Gastro-Intestinal Stroma Tumour (GIST), please state:

(a) Tumour classification (TNM classification) _____

(b) Mitotic count (in HPFs) _____

19. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.

C. Details of treatment

20. (a) Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.

Type of Treatment	Date of Treatment (dd/mm/yyyy)	Duration of Treatment

(b) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view/course of action is taken.	☐ Yes ☐ No
(c) i. Was radical surgery (total and complete removal of the affected organ) done? If "Yes", please state the name of the surgery, surgical code/table. Date surgery was performed (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
ii. For mastectomy cases, was reconstructive surgery done or recommended? If "Yes", please state date surgery was performed (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

21. Is the Insured still on follow-up at your clinic? ☐ Yes ☐ No

If "Yes", please provide state date of next appointment (dd/mm/yyyy) _____ /_____ /_____

If "No", please provide date of discharge (dd/mm/yyyy) _____ /_____ /_____

22. (a) Is the Insured terminally ill, i.e. death is expected within 12 months? ☐ Yes ☐ No

If "Yes", please provide details on the basis of your evaluation.

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

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

(b) Is the Insured referred to hospice care? ☐ Yes ☐ No

If "Yes", please state:

Name of hospice _____

☐ Inpatient – Date of admission (dd/mm/yyyy) _____ /_____ /_____

☐ Day care – Start date (dd/mm/yyyy) _____ /_____ /_____

23. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.

Name of doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

D. Additional information

24. Has the Insured ever had any malignant, pre-malignant or other related conditions or risk factors? ☐ Yes ☐ No
If "Yes", please provide details, including diagnosis, date of diagnosis, dates of consultation, name and address of doctor/ clinic and source of information.

25. Please give details of the Insured's medical history which would have increased the risk of Cancer (including nature of illness, date of diagnosis and source of information).

26. Please give details of the Insured's family history which would have increased the risk of Cancer (including the relationship, nature of illness, date of diagnosis and source of information).

27. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

28. Please give details of the Insured's habits in relation to alcohol consumption, including the type of alcohol, amount of alcohol consumption per day, duration of such consumption and source of this information.

29. Is the tumour or cancer in any way caused directly or indirectly by alcohol or drug abuse? ☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

30. Is the tumour in the presence of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

If "Yes" please state:

(a) HIV antibody status _____

(b) Date of diagnosis for HIV/AIDS (dd/mm/yyyy) _____ /_____ /_____

31. Does Insured have or ever had any other significant health condition(s)? ☐ Yes ☐ No

If "Yes", please provide details.

Diagnosis	Name of doctor	Name and address of clinic/ hospital	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

32. Please provide us with any other additional information that will enable us to assess this claim.

_____ _____

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

_____ _____

Name and qualification (printed) | Address & official stamp of clinic/hospital