Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6332 1133 · Fax: 6338 1500
Email: healthcare@income.com.sg · Website: www.income.com.sg

Scan to update your particulars

ElderShield Supplement/Care Secure Claim Form

Dear Policyholder

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.

2. Call the clinic to make an appointment for the disability assessment. Please refer to the list of appointed assessors at http://www.income.com.sg. The fee for the assessment is to be paid by you. Please note that this is required in order for the assessor to proceed with the assessment.

3. Bring along the following for the appointment:
   a. Completed ElderShield Supplement/Care Secure Claim Form
   b. A copy of your NRIC/Passport/Long-Term Pass, the payee's NRIC/Passport/Long-Term Pass and your caregiver's NRIC/Passport/Long-Term Pass (if payee and/or caregiver is other than the Policyholder)
   c. Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   d. Hospital medical records and Inpatient discharge summary. Please note that this is required in order for the assessor to proceed with the assessment.
   e. Medicine (if any)

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

If you need help, please contact our customer service officers on **6332 1133** or email us at **healthcare@income.com.sg**.

income made yours

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ElderShield Supplement/Care Secure Claim Form

To be completed by Policyholder

Please complete the following:

ElderShield Supplement Policy number _____

Care Secure Policy number _____

Personal particulars

Policyholder				
Full name of policyholder (as shown in NRIC/Passport/Long-Term Pass)				
NRIC number	Nationality	Date of birth (dd/mm/yyyy)	Ethnic group ☐ Chinese ☐ Indian ☐ Malay ☐ Others	Gender ☐ Male ☐ Female
Address				
Contact number (Handphone) (Office) (Home)			Email	
Caregiver (Age above 21 years old)				
Full name of caregiver (full-time or part-time)			Nationality	
Address of caregiver				
Relationship to policyholder			NRIC number	
Contact number (Handphone) (Office) (Home)			Email	
Bank account for benefits payment once claim is admitted (Please submit a copy of your bank book or statement for account verification. You need to circle the account for crediting if your statement shows more than 1 bank account) **Note: For payment to third party (family member or caregiver), please complete the attached Letter of Undertaking & Indemnity.**				
Name of bank account holder			Bank account number	
Name of bank			Name of branch	
Details of dependant (for Care Secure only) or child below age 21 (for PrimeShield only)				
Full name of dependant/youngest child		Date of birth (child)	Place of birth (child)	Gender ☐ Male ☐ Female
Birth certificate/NRIC number (Please submit copy of birth certificate/NRIC)			If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy): _____ (*Please submit copy of legal adoption papers*)	

Details of claim and medical history

1. Please state the conditions that the insured is suffering from and resulting in this claim in the table below.

Condition	Date of Diagnosis	Date symptoms first started	Description of symptoms

Details of claim and medical history (continued)

2. Doctors consulted for the conditions:

Condition	Date/Period of consultation(s)	Name and address of doctors consulted

3. If disability is due to accident, please provide date of accident _____ (dd/mm/yyyy), and attach a copy of accident report.
If no report is available, please describe: (a) nature of the accident; and (b) extent of injuries sustained.

4. Does the insured suffer from any other medical condition or disability? ☐ Yes ☐ No
If yes, please provide details:

Condition	Date condition was first diagnosed	Name and address of doctors consulted

5. Name and address of the insured's regular doctor:

Other insurance

Does the insured have insurance coverage with other insurance companies? ☐ Yes ☐ No
If yes, please provide details:

Name of insurer	Date of policy issue	Type of plan	Sum Assured (S$)	Claim notified (?)

Preferred servicing advisor for this claim

Do note that all communications pertaining to this claim will be sent to the advisor who last sold to the policyholder a policy with the same benefit that the claimant is claiming under this form. If the claimant prefers to have a different servicing advisor* for this claim, please indicate below and provide the details of the preferred servicing advisor*.

☐ I prefer to have the communications relating to this claim copied to the preferred servicing advisor* indicated below.

Name of advisor: _____

Contact number of advisor: _____

* The preferred servicing advisor must be an advisor to the policyholder's (where this claim is relating to) existing individual life policy with Income. Otherwise, your preference indicated above will not be valid and communications pertaining to this claim will be sent to the advisor who last sold to the policyholder a policy with the same benefit.

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

If the Policyholder has previously been assessed by a doctor to lack mental capacity*, the Policyholder's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated Policyholder need not sign off/affix thumbprint.

* A separate doctor's memo should be submitted to indicate that the Policyholder lacks mental capacity, including the relevant medical reason(s).

1. I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.
2. I declare that the answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information.
3. 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. I further confirm on the representation and warranty made in the PDUS.
4. I confirm that I am authorised to disclose information (including personal information) about the insured if this claim is made on behalf of them.
5. For the purpose of administering and processing my claim, I 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 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 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 agree that a copy of the authorisation in this form is valid and binding as an original copy.
6. I consent and agree to the transfer and disclosure, at any time and without notice or liability to me, of any policy or claim information, including about the life insured and claimant(s), in the insurer's possession to the Central Provident Fund Board and its approved insurer(s), and their representatives and third party service provider(s) for:
   a. the purpose of administering the claims made under the Dependant's Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act 1953. which I may be insured under; or
   b. any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act 1953. In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
7. I confirm that all copies of the claim documents that I have submitted to Income are copies of the original documents and I agree to retain all original documents for a period of 6 months from claim submission date for Income to verify its authenticity.
8. I am 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.
9. 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 nor will I make any claim against any other source for the same bill(s)/invoice(s).
10. If I have made a claim from other source,
    a. I agree that I will provide a copy of any document requested by Income of the payment received by me;
    b. I am aware that Income will not reimburse me if I have been fully reimbursed by such source;
    c. I am aware that Income may only reimburse me up to the remaining balance of the unpaid bill/invoice I have been partially reimbursed by such source;
    d. I undertake to refund on demand any payment made by Income to me which exceeds what I have incurred in total.
11. I understand that I must give Income all documents, authorisations or information required by Income to assess the claim. If I fail to co-operate with Income in administering and processing the claim, I am aware that the assessment of the claim may be delayed or Income may reject the claim.
12. I agree that if I or any #Relevant Person is found to be a +Prohibited Person:
    - if any policy is issued, you are entitled to end this policy, not pay any benefit or not allow any transaction, such as surrender and assignment, to be carried out under this policy. You will not refund any unutilised premium when this policy is ended.

    Your decision in every respect of the above will be final.

    I will inform you immediately if there is any change in my or any Relevant Person's identity, status or identity documents.

    # *Relevant Person includes insured, trustee, settlor, beneficiary, assignee, nominee, payee, mortgagee, financier of this application/policy, and in relation to an entity, its director, partner, manager, person having executive authority, authorised signatory, shareholder or beneficial owner.*

    \+ *Prohibited Person means a person or entity who is, or who is ^Related to a person or entity:*
    - *subject to laws, regulations or sanctions administered by any inter-government, government, regulatory or law enforcement authorities of any country, which will prohibit or restrict you from providing insurance or carrying out any transaction under this policy, or*
    - *who is involved in any terrorist or illegal activities or placed on sanctions listing or issued with freezing order.*

    ^ *Related includes relationships such as parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling, adopted sibling, parent-in-law, child-in-law, sibling-in-law, cousin, uncle, aunt, grandparents, niece, nephew, grandchild, employee, employer, associate, parent company, subsidiary and shareholder.*
13. I understand and agree that a copy of communication by email or postal mail between Income and I relating to this claim will be sent to the advisor who last sold to the policyholder a policy with the same benefit that I am claiming under this form except where I have indicated in this form a preferred servicing advisor who is also an advisor to the policyholder's existing individual life policy with Income.
14. I 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.
15. I agree to refund in full the monies which is paid by mistake or which I am not entitled to receive to Income immediately upon Income's request or once I found out on such mistake or wrong payment.
16. I understand and agree that once Income made payment for a claim under this form to me (including any subsequent payment arising from this claim) whether to the bank account provided by me in Income's latest record or by cheque, whichever applicable, Income's liability for such claim will be released and discharged accordingly.

Full name of Policyholder	NRIC number	Signature or thumbprint of Policyholder	Date signed (dd/mm/yyyy)

Declaration and authorisation (continued)		
To be completed if form is filled up by family member		
Full name of family member	NRIC of family member	Relationship to Policyholder
Address of family member	Signature of family member	Date signed (dd/mm/yyyy)
Contact number (Handphone) (Office) (Home)		

Important Note:

1. **This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this letter will facilitate the prompt processing of your claim.**
2. **Please complete this form if payment is to be made to a Third Party.**

To be completed by payee

To: Income

Part I: Letter of Undertaking & Indemnity

I/We declare that I am/we are the main caregiver(s) of the Policyholder, _____
Full name of Policyholder

_____ of NRIC number _____
NRIC number of Policyholder

Policy number _____

In consideration of Income agreeing, at the Policyholder's/my/our request to pay the benefits which the Policyholder is entitled to under Income's ElderShield Supplements or Care Secure insurance (" the Benefits") to me/us, I/we agree and undertake as follows :

1. That I/we will first use and apply the Benefits paid by Income for the care and benefit of the Policyholder.
2. That I/we will inform Income immediately upon becoming aware that the Policyholder has passed away or ceases to be entitled to the Benefits. I/we will repay any Benefits which the Policyholder is not entitled or ceases to be entitled to upon written demand by Income.

I/We agree and undertake that if I/we fail to make such repayment, I/we will fully indemnify Income against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred by Income as a result of my/our failing to fully repay the benefits or if Income has to enforce its rights under this Undertaking and Indemnity.

Part II: Direct credit authorisation

Kindly attach a copy of the bank book or statement showing the bank's name, branch and account number for our action.

I authorise Income to credit the Benefits into this account and to verify my/our account with the bank:

Full name of account holder(s) : _____

Name of bank : _____

Name of branch : _____

NRIC number :

								—		

Account number :

Details of payee (Age above 21 years old)		
Full Name of payee	NRIC number	Contact number
Address		Nationality
Signature of payee	Relationship to Policyholder	Date signed (dd/mm/yyyy)
Full Name of Policyholder	Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)

For homes or institutions only (If benefits are to be made to the home or institution)			
Full name of home or institution		Address of home or institution	
Full name of authorised officer	Contact number of authorised officer	Official stamp of home or institution	
Signature of authorised officer	Date signed (dd/mm/yyyy)		
Full Name of Policyholder		Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)