Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

Dear Customer, please email your claim to groupclaim@income.com.sg to avoid delay in the processing.

Group Dental/Outpatient/Hospitalisation Benefit Claim Form

Important notes

1. The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or medical report must be given at the expense of the employer or employee/member/patient.

2. Please email the following documents to **groupclaim@income.com.sg** within 30 days from the patient's date of visit to the clinic/hospital:
   (a) Duly completed and signed claim form. Please indicate as "N.A" if not applicable.
   (b) Copy of Final Hospital Bills and Inpatient Discharge Summary (if you are claiming for Hospitalisation Benefit}
   (c) Original final tax invoices (itemised bills), bills and receipts showing the patient's name, date of treatment
   (d) Copy of referral letter from general practitioner to panel specialist or hospital (if you are claiming for specialist visit)

   Please ensure that all required documents are completed and submitted together with this claim form to avoid any delay in processing your claim.

To be completed by employer and employee/member

Company name: _____ **Policy number:** _____

Particulars of employee/member

Particulars of employee/member (as shown in NRIC, FIN or Passport)				
Full Name (as shown in NRIC, FIN or Passport)		NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality	Country of residence	Occupation	Date of employment (dd/mm/yyyy)	Contact number
Email address		Address		

If your contact particulars (i.e. address, contact number and email address) 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.

Particulars of patient (If patient is a dependant of the employee/member) (as shown in NRIC, FIN, Passport or BC)			
Full Name (as shown in NRIC, FIN, Passport or BC)	NRIC, FIN, Passport or BC number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality / Country of residence	Relationship to employee/member ☐ Spouse ☐ Child	Occupation	

Details of the claim

1. Details of the claim

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

Medical Condition (For Hospitalisation Benefit & Specialist claim only)

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 referring General Practitioner or Clinic	h. Name and address of regular 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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. 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.	☐ Yes ☐ No

Payee's details

5. Benefits should be made payable to ☐ Employer/Union ☐ Employee/member

Name of bank _____ Branch _____

Account number _____

[2] If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under this claim and not be liable for any losses incurred by you (Please submit a copy of bank book or statement for account verification).

Name of payee (as shown in the bank account)	NRIC, FIN or Passport number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

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, 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 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)