income made yours

**NTUC Income Insurance Co-operative Limited**
Income Centre 75 Bras Basah Road Singapore 189557
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Scan to update your particulars via me@income

# Claim form for Child Illness Rider

**Important notes**

1. The acceptance of this form is not an admission of liability on the part of Income.
2. Medical report must be given at the expense of the policyholder or insured.
3. Please ensure that both Section 1 and Section 2 of the claim form are completed before you submit the claim.

## Section 1 – To be completed by policyholder or insured

### Particulars of policyholder or insured

| Full name of insured (as shown in NRIC/Birth Certificate) | Policy number | NRIC/Birth Certificate number |
|---|---|---|
| | | |
| Address of insured | | |
| | | |
| Full name of policyholder (as shown in NRIC/Passport) | Relationship to insured | NRIC/Passport number |
| | | |
| Residential address of policyholder | | |
| | | |

If your contact particulars (i.e. address, contact number and email) indicated in this form are different from your existing records with us, we will not update any of your existing policies with the new contact particulars.

### Record of medical consultations

1. Please provide details of any other doctors or specialists the insured has consulted in connection with this illness or injury

| a) Name and address of hospital or clinic | b) Date of first consultation |
|---|---|
| | |

2. Name and address of insured's regular doctor

3. Please tick the condition which you are claiming for.

| | |
|---|---|
| ☐ Severe asthma | ☐ Leukaemia |
| ☐ Bone marrow transplant | ☐ Insulin-dependent diabetes mellitus |
| ☐ Still's disease | ☐ Rheumatic disease with valvular impairment |
| ☐ Kawasaki disease | ☐ Haemophilia |
| ☐ Mental retardation due to sickness, injury or accident | ☐ Accidental fracture of skull, spine, pelvis or femur |

## 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 https://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 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, 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.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

## Declaration and authorisation

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" above.
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.
6. I agree that a copy of the authorisation in this form is valid and binding as an original copy.
7. 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.

| Full name and signature of policyholder | NRIC number of policyholder | Date signed (dd/mm/yyyy) |
|---|---|---|
| Full name and signature of patient or insured person (If different from Policyholder and age above 21 years) | NRIC number of patient or insured person | Date signed (dd/mm/yyyy) |

*Please ensure that "Attending Physician's Statement for Child Illness Rider" on the next page is completed.*

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# Attending Physician's Statement for Child Illness Rider

**Section 2 – To be completed by the attending doctor**

## Part 1: General Information

| |
|---|
| 1. Are you the patient's usual medical doctor? If 'Yes', over what period do your records extend to? |
| 2. When did the patient first consult you for this condition? |
| 3. When you first saw the patient, what were the symptoms presented and how long did they last? Please state the date that the symptoms began. |
| 4. In your opinion, how long has the patient been having these symptoms? Please provide reasons. |
| 5. Did the patient consult any other doctors for these symptoms before consulting you? |
| 6. What is the diagnosis? Please provide full details of the diagnosis, including the date of diagnosis. |
| 7. When did the patient or the parent first become aware of the condition? |

## Part 2: Details of child's illness (Please fill in the appropriate section.)

**1. Severe asthma**

| | | |
|---|---|---|
| a) Has there been a history of status asthmaticus within the past two years? | ☐ Yes | ☐ No |
| b) Did the patient exhibit significant and continuous reduction in exercise tolerance? | ☐ Yes | ☐ No |
| c) Were there chest deformities resulting from chronic hyperinflation? | ☐ Yes | ☐ No |
| d) Was there a need for medically prescribed oxygen therapy at home? | ☐ Yes | ☐ No |
| e) Was the patient on continuous daily use of oral corticosteriods (for at least six months)? | ☐ Yes | ☐ No |

**2. Leukaemia**

| |
|---|
| a) Please provide details of any chemotherapy or radiotherapy treatment provided, including the dates and type of treatment provided. |
| b) Please provide details of all investigations performed. |

**3. Bone-marrow transplant**

| | | |
|---|---|---|
| a) What is the underlying condition for which the patient needs a bone-marrow transplant? | | |
| b) Has the patient had a bone-marrow transplant?<br>If 'Yes', please provide the date of the transplant and the name of the hospital where the transplant was performed. | ☐ Yes | ☐ No |
| c) If the patient has not had a bone-marrow transplant, has the patient been confirmed as accepted on the official waiting list of the medical or health authorities in Singapore for a transplant, as a recipient?<br>If 'Yes', please provide the date and the details where the patient was placed on a waiting list. | ☐ Yes | ☐ No |

**4. Insulin-dependent diabetes mellitus**

| | | |
|---|---|---|
| a) Was the presence of severe diabetes mellitus characterised by: | | |
| i. loss of plasma insulin levels; | ☐ Yes | ☐ No |
| ii. episodic ketoacidosis? | ☐ Yes | ☐ No |
| b) Please give details if the patient is insulin-dependent and enclose a copy of the blood and urine test results. | | |
| c) Was there evidence of decreasing C-peptide? Please provide details. | | |
| d) Please give details of all investigations done and treatment prescribed. | | |

**5. Rheumatic disease with valvular impairment**

| | | |
|---|---|---|
| a) Was there impairment or damage to one or more heart valves and was this supported by an echocardiogram? | ☐ Yes | ☐ No |
| b) Was there evidence of a history of rheumatic fever? | ☐ Yes | ☐ No |
| c) Please give details of any group-A streptococcus infection with supporting evidence. | | |
| d) Please provide details of all investigations carried out and enclose copies of the results of the echocardiogram and laboratory investigations. | | |

**6. Kawasaki disease**

| | | |
|---|---|---|
| a) Was there cardiac involvement with dilation or aneurysm formation in coronary arteries which lasted at least six months after the initial acute episode?<br>If 'Yes', please provide details including the date it began and how long the coronary artery dilation or aneurysm formation lasted. Please enclose copies of investigations carried out confirming this. | ☐ Yes | ☐ No |

**7. Haemophilia**

| | | |
|---|---|---|
| a) Was the condition mild, moderate or severe? | | |
| b) Was the clotting factor VIII less than 1%? | ☐ Yes | ☐ No |
| c) Was the clotting factor IX less than 1%? | ☐ Yes | ☐ No |

**8. Still's disease**

| | | |
|---|---|---|
| a) Does the patient show the features of Still's disease? Please provide details. | | |
| b) Does the patient need a knee or hip replacement? If 'Yes', please provide details. | ☐ Yes | ☐ No |
| c) Please enclose copies of all laboratory test results, including blood-test results. | | |

**9. Mental retardation due to sickness, injury or accident**

| | | |
|---|---|---|
| a) Was the condition caused by sickness, injury or accident? | ☐ Yes | ☐ No |
| b) If the condition was due to injury or accident:<br>i. please provide the date of the accident and give details of the circumstances leading to the injury or accident. | | |
| ii. Were there any contributory factors leading to the injury or accident? (For example, the influence of alcohol or drugs, self-inflicted injury, etc.) | | |

| | | |
|---|---|---|
| c) If the condition was due to sickness:<br>i. please provide the date the sickness began. | | |
| ii. what were the underlying conditions? | | |
| d) Has the condition continued without interruption for at least six months in a row after diagnosis? | ☐ Yes | ☐ No |
| e) Was the condition caused by congenital illness or condition? | ☐ Yes | ☐ No |
| **10. Accidental fracture of the skull, spine, pelvis or femur** | | |
| a) Was the patient's condition due to an accident? | ☐ Yes | ☐ No |
| b) Did the accident result in a fracture of the skull, spine, pelvis or femur? | ☐ Yes | ☐ No |
| c) Did the fracture involve the insured staying in hospital for treatment? | ☐ Yes | ☐ No |
| d) Was the patient's condition a hairline fracture which does not involve the periosteum or the articular surface? | ☐ Yes | ☐ No |
| e) Was the patient's condition due to self-inflicted injuries? | ☐ Yes | ☐ No |
| f) Was the patient's condition caused by drug or alcohol abuse or misuse? | ☐ Yes | ☐ No |
| g) Please provide details of the accident. | | |
| i. Date of accident (dd/mm/yyyy): | | |
| ii. Time of accident | | |
| iii. Place of accident | | |
| iii. Describe the extent of the injury and give details of the anatomical site involved. | | |
| h) Please enclose copies of the X-ray. | | |

## Other useful information

1. Please provide us with any other information that will be helpful in assessing this claim.

2. We would appreciate it if you could enclose copies of all relevant diagnostic and laboratory test results.

| | |
|---|---|
| Signature of doctor or medical officer-in-charge | Date (dd/mm/yyyy) |
| Name (in block letters) | Address and official stamp of hospital or clinic |