income made yours

**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

Scan to update your particulars via me@income

# Checklist for Medical/Accident/Living/Total and Permanent Disability Claim (Individual Policies)

**Dear claimant**

We are sorry to learn of your illness/injury/hospitalisation. In order for us to process your claim, we require the following (please tick 'V' the appropriate box and enclose the required documents):

**Important notes**

(a) All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
(b) We encourage you to opt for Direct Crediting under the Payment Method section of the claim form for payment to reach you faster.
(c) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible.
(d) All overseas documents must be certified as true copies by your lawyer or any Notary Public.
(e) All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/ interpreter.
(f) Please continue to pay the premiums to keep your policy in force.

☐ **Total and Permanent Disability Claim/Terminal Illness Claim/Disability Care**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passport, birth certificate) of claimant

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

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

_____ Medically boarded out letter (where applicable)

_____ Newspaper clipping and Police/Accident Report (if Total & Permanent Disability or Permanent Incapacity was due to accidental or violent causes)

_____ Termination letter from last employer OR CPF Statement showing last employment contribution (for DPS policy only)

_____ CPF Contribution Statement for the past 15 months (for DPS policy only)

_____ Dependant Booster Benefit Claim Form (for Family Protect policy only), to be completed by claimant

☐ **Dread Disease (Living) Claim/Female Illness/Senior Illness/Juvenile Illness**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passports, birth certificates) of claimant

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

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

Note: Please use the specific AMPS form if claimant is claiming under the following medical conditions:
Cancer/Major Cancers, Benign Brain Tumour, Kidney Failure, Stroke, Heart Attack/Coronary Artery By-pass Surgery/Angioplasty and Other Invasive Treatment for Coronary Artery, Heart Valve Surgery/Percutaneous Valve Surgery, Parkinson's Disease, Surgery to Aorta/Large Asymptomatic Aortic Aneurysm.

☐ **Medical Claim**

☐ **Incomeshield (Non-Integrated - where premiums are not paid using CPF funds), Family Plus, Annuity Hospital & Surgical, Managed Healthcare System (Inpatient)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Final hospital/medical bills & receipts

_____ Hospital discharge summary

_____ Medical reports, if available

_____ A copy of the settlement letter from the Insurer/Employer (If there is previous reimbursement from another Insurer/Employer)

_____ A copy of insured's passport and eligible valid pass if insured is a foreigner and is claiming for Emergency overseas treatment

☐ **Hospital Benefit (Rider)/Hospital Cash Benefit**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ A copy of the Final hospital bills

_____ Hospital discharge summary

_____ Medical reports, if available

_____ Medical Certificates, if available

☐ **Accident Claim (Accident Benefit)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Hospital discharge summary

_____ Medical Certificates

_____ A copy of the Final hospital bills & receipts

_____ Medical reports

_____ Accident reports

_____ Police Report, if any

☐ **Retrenchment Benefit**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form to be completed by claimant (to complete these sections: Policy number, Plan Type, Particulars of Insured, Other Information, Payment Method, Declaration and Authorisation)

_____ Retrenchment letter from employer stating reason(s) for the retrenchment

_____ CPF Statement showing last 6 months' contribution prior to retrenchment and cessation of contribution for at least 3 months after retrenchment

☐ **Maternity 360**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passport, birth certificate) of claimant

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

_____ Child's birth certificate (for claim on child's benefit)

_____ Child's health booklet (for claim on child's benefit)

_____ A copy of the final itemised/detailed hospital bills

Please submit all claim documents at any of our branches[2], OR through your insurance adviser, OR by post to:

Branch Claim Services
NTUC INCOME Insurance Co-operative Limited
75 Bras Basah Road
INCOME Centre
Singapore 189557

[2] Please refer to our website **www.income.com.sg** for the location and opening hours of our branches.

If you need any assistance, please contact our Customer Service Officers or email us:
1. Personal life claims: **6788 1122** or **csquery@income.com.sg**
2. IncomeShield claims: **6789 6886** or **healthcare@income.com.sg**
3. Group life insurance claims: **6332 1133** or **groupclaim@income.com.sg**

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# Medical/Accident/Living/Total and Permanent Disability Claim Form (Individual Policies)

**Important Notice**
The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income shall be furnished at the expense of the policyholder or claimant (depending on plan types). To avoid delay in processing your claim, please submit the duly completed claim form together with the supporting documents within 30 days from date of occurrence.

Claim Type (For Individual life policies only) – Please tick '✓' the appropriate box:

| | |
|---|---|
| ☐ Accident Benefit | ☐ Disability Care |
| ☐ Dread Disease Benefit | ☐ Female Illness/Senior Illness/Juvenile Illness Benefit |
| ☐ Hospitalisation Benefit | ☐ Maternity 360 |
| ☐ Retrenchment Benefit | ☐ Others _____ |
| ☐ Total and Permanent Disability Benefit/Terminal Illness Benefit | |

| Policy number(s) | Plan type | Claim number |
|---|---|---|
| | | |

## Particulars of insured

| | | |
|---|---|---|
| Full name of insured (as shown in NRIC/Passport/Birth Certificate) | NRIC/Passport/Birth Certificate number | Gender ☐ Male ☐ Female |
| Occupation (If unemployed, please indicate last occupation) | ☐ Employed ☐ Self Employed ☐ Unemployed | Date of birth (dd/mm/yyyy) |
| Name and address of employer or last employer (if unemployed) | Period of employment (dd/mm/yyyy) From _____ To _____ | |
| Full name of policyholder (if different from insured) | NRIC/Passport number | Gender ☐ Male ☐ Female |
| Address | | |
| Contact number (Office) (House) (Hand phone) | Email | |

## For Accident/Disability claims only

1. a. Date the insured last worked (dd/mm/yyyy) : _____

   b. Date the insured returned to work (dd/mm/yyyy) : _____ OR

   Date the insured expect to return to work (dd/mm/yyyy) : _____

## Medical Condition/History

**2. Details of illness/injury**

Is the condition/disability suffered due to ☐ Illness ☐ Accident

a. If the condition/disability suffered is due to illness, please provide

(i) Diagnosis _____

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

(iii) Describe in detail all symptoms and nature of medical condition/disability suffered.

## Medical Condition/History (continued)

b. If the disability suffered is due to accident, please provide

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

(iii) Place of accident _____

(iv) Detailed description of nature of injuries/disability suffered

(v) Detailed description of accident (Please enclose a copy of the police report, if any)

(vi) If you are claiming for accident inpatient dental treatment, please advice which tooth/teeth were injured?

Was/were the injured teeth sound natural? ☐ Yes ☐ No

c. (i) Please state the periods of hospitalisation

| Name of hospital | Period of hospitalisation | |
|---|---|---|
| | From (dd/mm/yyyy) | To (dd/mm/yyyy) |
| | | |
| | | |
| | | |

(ii) Has the insured been given hospital/medical leave? ☐ Yes ☐ No

If "Yes", please state the start and end date of the hospital/medical leave.

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

3. How was the insured admitted to the hospital?

☐ Referral by a General Practitioner/Specialist/Other hospital (please delete accordingly)

Please provide the name and address of referring doctor/hospital.

_____

_____

☐ A & E department

4. Please provide the name, contact number and address of the doctor who is treating the insured for his current condition/injury.

5. Was surgery performed for this condition? If "Yes", please provide details below. *(For Medical/Accident claims only)* ☐ Yes ☐ No

| Surgical operation/procedure | Date(s) of operation/procedure (dd/mm/yyyy) | Surgical code/table (please refer to your doctor) |
|---|---|---|
| | | |
| | | |

## Medical Condition/History (continued)

6. Has this or similar condition/injury been treated before? If "Yes", please provide details below. ☐ Yes ☐ No

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

7. Has the insured seen other doctors besides those indicated above? If "Yes", please provide details below. ☐ Yes ☐ No

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

8. Please provide details of the insured's regular doctor(s) and company doctor(s) below:

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

## Other insurances

9. Is the insured covered for medical expenses by any other insurance company (ies), his employer or any other parties? If "Yes", please state details below. ☐ Yes ☐ No

10. Is the insured claiming from any other insurance company (ies) or other sources (employer, other medical insurances, Workmen's Compensation Act) in respect of this condition/injury? If "Yes", please provide the following information. ☐ Yes ☐ No

| Name of employer, Insurance company etc. | Policy number | Date of issue (dd/mm/yyyy) | Type of plan | Claim amount | Claim notified (Yes/No) | Claim paid (Yes/No) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**For medical claims, please provide a copy of the respective settlement letter from the other insurance company or other sources.**

Note: It is important to inform us if you are claiming from other insurance companies, your employer or any other parties for the same bill. You can only claim or be reimbursed for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover the excess amount paid to you.

## Other information

**11. 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

**Please tick one of the boxes below to indicate payment method:**

☐ Credit into my personal bank account (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) - We encourage you to opt for Direct Crediting for payment to reach you faster.

☐ Cheque to be mailed directly to the claim recipients

## 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 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 (Chapter 36) 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 (Chapter 36).

   In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
8. I also understand that the claim benefit that I will be receiving under Dependants' Protection Insurance Scheme, subject to the approval of my claim application, will be the sum assured that I was covered for as at the date when my incapacity commenced as stated in my medical certification.
9. 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.
10. 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.
11. 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).
12. 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.
13. 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/thumbprint of **policyholder** (individual) | | NRIC/Passport number | Date signed (dd/mm/yyyy) |
| Full name and signature/thumbprint of **insured** who is 21 years old or above (if different from policyholder) | | NRIC/Passport number | Date signed (dd/mm/yyyy) |
| Full name and signature of **claimant** who is 21 years old or above (if the policyholder/insured does not have the mental capacity or is below 21 years old) | Relationship to policyholder | NRIC/Passport number | Date signed (dd/mm/yyyy) |
| Please indicate why policyholder/insured is unable to sign | | | |