

30-day Protect Data Plan Free Cover claim form

Important notice

- If we accept this form, this 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 it.
- 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 of policyholder (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
Contact number (Office) (Home) (Handphone)	Email	
Note: For death claim, to fill in the details of the person filing the claim under the policyholder.		

Personal details of insured (Do not fill this in if it is the same as above)

Full name (as shown in NRIC)	NRIC 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
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For payment by PayNow (registered with **NRIC No. only**)

Details of incident, injury or illness

Date of incident (dd/mm/yyyy)	Time of incident <input type="checkbox"/> am <input type="checkbox"/> pm	Place of incident
Say what happened		
Nature and extent of injury or illness sustained		

1. Has the insured person previously suffered a similar injury or illness?
If Yes, please give details.

Yes No

2. How long was the hospital stay?

Supporting documents

(A) If you are claiming for **Accidental death**, please send to us the following.

1. A copy of the death certificate
2. The autopsy report, toxicological report and coroner's findings
3. Proof of your relationship with the person who died

Policyholder or person claiming	Documents needed
Husband or wife	Marriage certificate
Parent	Birth certificate of person who has died
Child	Birth certificate of policyholder or person claiming
Brother or sister	Birth certificate of person who has died and policyholder or person claiming

4. Newspaper clipping and police or accident report
5. Last will of the person who died (if they left a will) or letter of administration (if there is no will)

(B) If you are claiming for **Permanent disability**, please send to us the following.

1. Inpatient discharge summary (if you have to stay in hospital)
2. Newspaper clipping and police or accident report
3. A filled-in medical report (see 4th page of the claim form)

(C) If you are claiming for **Daily hospital income after more than 4 days of hospitalisation due to an accident**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary (if you have to stay in hospital)
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(D) If you are claiming for **Get well benefit after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(E) If you are claiming for **Job loss after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)
5. Letter from employer stating the reason of termination is due to no longer medically fit to perform the major duties connect with your employment

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.

Medical report

The doctor must fill this in.

(You will have to pay any costs involved in the doctor providing this report.)

Name of Patient	NRIC number		
1. Final diagnosis			
2. Date of diagnosis (dd/mm/yyyy)			
3. Nature of injury or condition and the extent of the injury			
4. Was the condition caused by an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No a) If Yes, please give the date of the accident (dd/mm/yyyy): _____ Time of accident: _____ AM/ PM Describe the accident _____ b) If No, please state the cause of condition: _____			
5. Was any surgery carried out for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide nature of treatment/name(s) of surgical procedure(s), surgical code & table.			
6. Was the insured under the influence of alcohol or drugs at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state the blood alcohol content or type of drug and the quantity consumed.			
7. Is the Insured's condition self-inflicted or as a result of attempted suicide? If Yes, please provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Is the injury likely to cause loss of use of the injured part? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Is the loss likely to be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.			
For illness (if this applies)			
1. Date of symptom first started (dd/mm/yyyy)	2. When did the patient first consult you about this condition?		
3. Details of present symptoms, nature and date of treatment given			
4. What were the underlying conditions? Please provide date of diagnosis			
5. Doctors previously consulted by the patient for the above condition:			
Name of doctor	Date of consultation	Name of clinic or hospital	Address
6. Has the patient fully recovered from the condition? If No, what follow up treatment are needed?			
_____ Signature of doctor		_____ Date (dd/mm/yyyy)	
_____ Name and position		_____ Name and address of clinic or hospital	