



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 information and document(s) (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 branches², OR through your insurance advisor, OR by post to:

Income Insurance 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:

Claims on individual policy: **6788 1122** or csquery@income.com.sg
Claims on IncomeShield policy: **6789 6886** or healthcare@income.com.sg
Claims on group policy: **6332 1133** or groupclaim@income.com.sg



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.

All benefits under IncomeShield will end when the insured, who is a foreigner, no longer has an eligible valid pass, and we will not be legally responsible for any further payment under this policy. Eligible valid pass means a valid pass with a foreign identification number (FIN) recognised by the Immigration and Checkpoints Authority of Singapore (ICA), for example, student's pass, work pass, long term pass and dependant's pass.

Claim Type (For Individual life policies only) – Please tick '✓' the appropriate box:	
<input type="checkbox"/> Accident Benefit <input type="checkbox"/> Dread Disease Benefit <input type="checkbox"/> Hospitalisation Benefit <input type="checkbox"/> Retrenchment Benefit <input type="checkbox"/> Total and Permanent Disability Benefit/Terminal Illness Benefit	<input type="checkbox"/> Disability Care <input type="checkbox"/> Female Illness/Senior Illness/Juvenile Illness Benefit <input type="checkbox"/> Maternity 360 <input type="checkbox"/> Others _____

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

Particulars of insured

Full name of insured (as shown in NRIC/Passport/Long-term Pass/Birth Certificate)	NRIC/Passport/Long-term Pass/Birth Certificate number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation (If unemployed, please indicate last occupation)	<input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> 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/Long-term Pass number	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Illness <input type="checkbox"/> Accident
a. If the condition/disability suffered is due to <u>illness</u> , 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 advise 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.			<input type="checkbox"/> Yes <input type="checkbox"/> 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.			<input type="checkbox"/> Yes <input type="checkbox"/> 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.						<input type="checkbox"/> Yes <input type="checkbox"/> 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.						<input type="checkbox"/> Yes <input type="checkbox"/> 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

Notes:

1. All future medical claims or claims payment by instalments will be paid to the bank account provided by you in our record. For other claims, we may request for a copy of your bank book or statement for account verification before we make payment.
2. We reserve the right to request for a copy of your bank book or statement for account verification before payment in any point in time where we deem necessary.
3. If there is a change of bank account, please submit to us a copy of your new bank book or statement for account verification and for us to update your bank account record with us.

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

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 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.
8. 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.
9. 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.
10. 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).
11. 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.
12. 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.

Declaration and authorisation (continued)

13. 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.
14. 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.
15. 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.
16. I confirm that the insured has an eligible valid pass. I am aware that all benefits under IncomeShield will end when the insured, who is a foreigner, no longer has an eligible valid pass, and Income will not be legally responsible for any further payment under the IncomeShield policy.
17. 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.
18. 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 and signature/thumbprint of policyholder (individual)		NRIC/Passport/Long-term Pass 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/Long-term Pass 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/Long-term Pass number	Date signed (dd/mm/yyyy)
Please indicate why policyholder/insured is unable to sign			