NTUC Income Insurance Co-operative Limited
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Scan to update your particulars via me@income

Managed Healthcare System (MHS) Outpatient Medical Claim Form

Important notes:
It is important to read the notes below before you complete the claim form.

1. The acceptance of this form is **not** an admission of liability on the part of Income. Any documentary proof or medical report shall be furnished at the expense of the policyholder.

2. Please submit the following documents within 60 days from date of visit:
   (i) Duly completed and signed original claim form
   (ii) Please keep the original final tax invoices (itemised bills), bills, receipts or relevant documents for the next 6 months. Income reserves the rights to call for the original copies of these documents for verification
   (iii) Copy of referral letter from panel general practitioner to panel specialist or hospital (if you are claiming for specialist visit)
   (iv) Copy of the attending physician's prescription for claims on purchase of drugs

3. Please use **one claim form per visit per patient**.

4. All required documents, duly completed and signed forms must be submitted to avoid any delay in claim processing. Please indicate "N.A" if not applicable.

5. An eligible claim will be reimbursed according to the following priority:
   - Policyholder if he or she has settled the eligible medical bills by cash
   - Medisave account as indicated in the tax invoices or bills
   - Patient's Medisave-approved Private Integrated Plan (if applicable)

To be completed by policyholder

1. Particulars of policyholder

1a. Policy number	1b. Full name (as shown in NRIC/Passport)		
1c. NRIC/Passport/FIN number	1d. Date of birth (dd/mm/yyyy)	1e. Gender ☐ Male ☐ Female	1f. Contact number
1g. Email address		1h. Address	

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

2. Particulars of insured (Compulsory if patient is spouse or child of policyholder)

2a. Full name (as shown in NRIC/Passport/Birth Certificate)			
2b. NRIC/Passport/Birth Certificate number	2c. Date of birth (dd/mm/yyyy)	2d. Gender ☐ Male ☐ Female	2e. Relationship to policyholder ☐ Spouse ☐ Child

3. Details of illness or injury

3a. Type of claim [1]	3b. Date of visit (dd/mm/yyyy)	3c. Description of illness or injury	3d. Name of referring GP and clinic (For specialist visit only)
☐ GP ☐ SP ☐ Others (Please specify) ________			

[1] "GP" refers to general practitioner and "SP" refers to specialist.

4. Please complete the following if you have sustained injury as a result of an accident

4a. Date (dd/mm/yyyy) and time of accident	4b. Place of accident	4c. Is it work-related? ☐ Yes ☐ No
4d. State how the injury or accident happened		
4e. Is the medical expenses claimable under your company's Work Injury Compensation Act Policy?		☐ Yes ☐ No

5. Other information

Are you making or intending to make a 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. **Note:** It is important that you inform us if you are claiming from other insurance 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.	☐ Yes ☐ No

Payment to be made by:

☐ Cheque

We encourage you to opt for Direct Crediting for payment to reach you faster.

☐ Credit into policyholder's bank account: Bank ______________ Branch ______________ Account number ______________

Is this your first time requesting for direct credit ☐ Yes ☐ No

If yes, please submit a copy of your bank account details page for set up purpose.

Note:

• Please update us if there is a change of bank account. Income is not liable if the account numbers or the recipient name you have provided are incorrect.

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 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.
8. 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.
9. 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).
10. 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.
11. 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/Passport/FIN number	Date signed (dd/mm/yyyy)
Full name and signature of insured (If different from policyholder and age above 21 years)	NRIC/Passport/Birth Certificate number	Date signed (dd/mm/yyyy)