income made yours

Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
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Enquiries: www.income.com.sg/enquiry

CancerAssist claim form

Important notice

- If we accept this form, it 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 them.
- 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 (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)
Home address		Occupation	Nationality
Contact number (Office) (Home) (Handphone)		Email	

Personal details of insured (No need to fill this in if the information is the same as above.)

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport 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

☐ For payment by PayNow (registered with **NRIC No. only**)

Claim details

1 Details of illness

a. Diagnosis ______________________________

b. Date symptoms started (dd/mm/yyyy) ______________________________

c. Describe in detail all symptoms and nature of medical condition suffered.

____

2 Please provide the name, contact number and address of the doctor who is treating you for your current condition.

3 Was any surgery carried out for this condition? If Yes, please provide details below. ☐ Yes ☐ No

Surgical operation or procedure	**Date of operation or procedure** (dd/mm/yyyy)	**Surgical code or table** (please ask your doctor)

4 Has the insured person previously suffered a similar condition? If Yes, please give details. ☐ Yes ☐ No

Supporting documents

The below documents which have been **marked** will be enclosed with the claim form.

- ☐ 1 Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor & submitted to us)
- ☐ 2 Medical reports/Laboratory reports/Hospital Discharge Summary

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

I/We cannot alter any of the wordings in this claim form. Any attempt to do so will have no effect.

I/We declare that the answers given in this form are true, correct and complete. I/We accept full responsibility for them, whether written by me/us or by anyone else on my/our behalf. I/We have not withheld any information. If it is discovered later that the insured suffers from a medical condition that is not disclosed in this form, I/we will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income.

I/We confirm that I/we understand and agree to the collection, use and disclosure of my/our personal data as stated in the "Personal Data Use Statement" (PDUS) above. I/We further confirm on the representation and warranty made in the PDUS.

If this claim is submitted under a group policy,

a. I, the insured, consent to (1) the group policyholder disclosing to Income; and (2) Income disclosing to the group policyholder, my personal data (including claims information and outcome) for the purposes of claims administration;
b. We, the group policyholder represent and warrant that we have obtained the consent from the insured (1) to disclose to Income the insured's personal data (including claims information and outcome); (2) for Income to disclose the insured's personal data including all claims information and outcome to the group policyholder to facilitate the administration of the claims that we have submitted in this form, where necessary.

For the purpose of administering and processing my/our claim, I/we 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/us 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/us 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/We confirm that all copies of the claim documents that I/we have submitted to Income are copies of the original documents and I/we agree to retain all original documents for a period of 6 months from claim submission date for Income to verify its authenticity.

I am/We are 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/us.

I/We confirm that I/we have paid in full all the bill(s)/invoice(s) that I/we have submitted to Income for reimbursement and I/we have not made nor will I/we make any claim against any other source for the same bill(s)/invoice(s).

If I/we have made a claim from other source, a. I/we agree that I/we will provide a copy of any document requested by Income of the payment received by me/us; b. I am/we are aware that Income will not reimburse me/us if I/we have been fully reimbursed by such source; c. I am/we are aware that Income may only reimburse me/us up to the remaining balance of the unpaid bill/invoice I/we have been partially reimbursed by such source; d. I/we undertake to refund on demand any payment made by Income to me/us which exceeds what I/we have incurred in total.

I/We understand that I/we must give Income all documents, authorisations or information required by Income to assess the claim. If I/we fail to co-operate with Income in administering and processing the claim, I am/we are aware that the assessment of the claim may be delayed or Income may reject the claim.

I/We 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.

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.

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Attending Medical Practitioner's Statement Cancer/Major Cancers

Part 1 (to be completed by the insured)

Policy number	Plan type	Claim number
Name of insured (as shown in NRIC)		NRIC number
Address of Insured		
Name of next-of-kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number
Address of next-of-kin		

Authorisation
I agree and authorise:
(a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to Income any information as requested by Income; and
(b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer or organisation or person.
A photocopy of this form is valid as an original copy

Signature/Thumbprint of insured/next-of-kin[1] Date (dd/mm/yyyy)

[1] Please delete accordingly

Part 2 (to be completed by the doctor)

Name of insured (as shown in NRIC)	NRIC number

A. General information

1. (a) Are you the Insured's usual doctor? ☐ Yes ☐ No

   (b) Over what period do your records extend?

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

2. When did the Insured first consult you for this condition? (dd/mm/yyyy): ______ /______ /______

3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

What / who is the source of this information?

Part 2 (to be completed by the doctor) (continued)

4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? If "Yes", please provide details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic / hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

B. Details of dread disease

5. (a) What is the histological diagnosis of the disease?

(b) Date of diagnosis (dd/mm/yyyy): _______ /_______ /_______

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

(d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy): _______ /_______ /_______

6. (a) Was a biopsy of the tumour performed? ☐ Yes ☐ No

If "Yes", please state the date of biopsy (dd/mm/yyyy): _______ /_______ /_______

If "No", please state why and how the diagnosis was confirmed.

(b) What was the site or organ involved?

(c) What is the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM Classification, etc.).

i. Has the cancer spread beyond the layer of cells in which it began?	☐ Yes ☐ No
ii. Was the disease completely localised?	☐ Yes ☐ No
iii. Was there invasion of adjacent tissues?	☐ Yes ☐ No
iv. Were regional lymph nodes involved?	☐ Yes ☐ No
v. Were there distant metastases? If "Yes", please provide full details, including site of any metastases, etc.	☐ Yes ☐ No
7. Is the condition carcinoma-in-situ?	☐ Yes ☐ No
8. Is the condition pre-malignant or non-invasive?	☐ Yes ☐ No
9. Is the condition having borderline malignancy or is suspicious of malignancy only?	☐ Yes ☐ No
10. Is the condition Cervical Dysplasia CIN 1, CIN 2, CIN 3 (severe dysplasia without Carcinoma-in-situ)?	☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

11. Is the condition Carcinoma-in-situ of the Biliary system?	☐ Yes ☐ No
12. Is the condition Hyperkeratoses, basal cell and squamous skin cancers?	☐ Yes ☐ No
13. (a) Is the condition Bladder Cancer described as TNM classification T1N0M0 or below?	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Bladder?	☐ Yes ☐ No
14. Is the condition Prostate cancer described as TNM classification T1N0M0, T1 or another equivalent or lesser classification? If yes, please circle: T1a / T1b / T1c	☐ Yes ☐ No
15. (a) Is the condition Thyroid Cancer described as TNM classification T1N0M0 or below? If "Yes", please state the size in diameter ____________ cm	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Thyroid? If "Yes", please state the size in diameter ____________ cm	☐ Yes ☐ No

16. If the diagnosis is leukaemia, please state:

(a) Type of leukaemia ____________

(b) RAI staging ____________

17. If the diagnosis is malignant melanoma, please give full details below:

(a) Size, Thickness (Breslow classification) (mm) ____________

(b) Depth of invasion (Clark level) ____________

(c) Has the condition caused invasion beyond the epidermis? ☐ Yes ☐ No

18. If the diagnosis is Gastro-Intestinal Stroma Tumour (GIST), please state:

(a) Tumour classification (TNM classification) ____________

(b) Mitotic count (in HPFs) ____________

19. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.

C. Details of treatment

20. (a) Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.

Type of Treatment	Date of Treatment (dd/mm/yyyy)	Duration of Treatment

(b) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view/course of action is taken.	☐ Yes ☐ No
(c) i. Was radical surgery (total and complete removal of the affected organ) done? If "Yes", please state the name of the surgery, surgical code/table. Date surgery was performed (dd/mm/yyyy) ______ /______ /______	☐ Yes ☐ No
ii. For mastectomy cases, was reconstructive surgery done or recommended? If "Yes", please state date surgery was performed (dd/mm/yyyy) ______ /______ /______	☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

21. Is the Insured still on follow-up at your clinic? ☐ Yes ☐ No

    If "Yes", please provide state date of next appointment (dd/mm/yyyy) _______ /_______ /_______

    If "No", please provide date of discharge (dd/mm/yyyy) _______ /_______ /_______

22. (a) Is the Insured terminally ill, i.e. death is expected within 12 months? ☐ Yes ☐ No

    If "Yes", please provide details on the basis of your evaluation.

    Please indicate the date on which the Insured is assessed to be terminally ill.

    (dd/mm/yyyy) _______ /_______ /_______

    (b) Is the Insured referred to hospice care? ☐ Yes ☐ No

    If "Yes", please state:

    Name of hospice ______________________________

    ☐ Inpatient – Date of admission (dd/mm/yyyy) _______ /_______ /_______

    ☐ Day care – Start date (dd/mm/yyyy) _______ /_______ /_______

23. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.

Name of doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

D. Additional information

24. Has the Insured ever had any malignant, pre-malignant or other related conditions or risk factors? ☐ Yes ☐ No
    If "Yes", please provide details, including diagnosis, date of diagnosis, dates of consultation, name and address of doctor/ clinic and source of information.

25. Please give details of the Insured's medical history which would have increased the risk of Cancer (including nature of illness, date of diagnosis and source of information).

26. Please give details of the Insured's family history which would have increased the risk of Cancer (including the relationship, nature of illness, date of diagnosis and source of information).

27. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

28. Please give details of the Insured's habits in relation to alcohol consumption, including the type of alcohol, amount of alcohol consumption per day, duration of such consumption and source of this information.

29. Is the tumour or cancer in any way caused directly or indirectly by alcohol or drug abuse? ☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

30. Is the tumour in the presence of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
    If "Yes" please state:
    (a) HIV antibody status ____________________
    (b) Date of diagnosis for HIV/AIDS (dd/mm/yyyy) ______ /______ /______

31. Does Insured have or ever had any other significant health condition(s)? ☐ Yes ☐ No
    If "Yes", please provide details.

Diagnosis	Name of doctor	Name and address of clinic/ hospital	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

32. Please provide us with any other additional information that will enable us to assess this claim.

Signature of doctor

Date (dd/mm/yyyy)

Name and qualification (printed)

Address & official stamp of clinic/hospital