



ElderShield Supplement/Care Secure Claim Form

Dear Policyholder

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.
2. Call the clinic to make an appointment for the disability assessment. Please refer to the list of appointed assessors at <http://www.income.com.sg>. The fee for the assessment is to be paid by you. Please note that this is required in order for the assessor to proceed with the assessment.
3. Bring along the following for the appointment:
 - a. Completed ElderShield Supplement/Care Secure Claim Form
 - b. A copy of your NRIC, the payee's NRIC and your caregiver's NRIC (if payee and/or caregiver is other than the Policyholder)
 - c. Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
 - d. Hospital medical records and Inpatient discharge summary. Please note that this is required in order for the assessor to proceed with the assessment.
 - e. Medicine (if any)

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

If you need help, please contact our customer service officers on **6332 1133** or email us at healthcare@income.com.sg.



ElderShield Supplement/Care Secure Claim Form

To be completed by Policyholder

Please complete the following:

ElderShield Supplement Policy number _____

Care Secure Policy number _____

Personal particulars

Policyholder

Full name of policyholder (as shown in NRIC)

NRIC number	Nationality	Date of birth (dd/mm/yyyy)	Ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address

Contact number (Handphone) (Office) (Home)	Email
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Caregiver (Age above 21 years old)

Full name of caregiver (full-time or part-time)	Nationality
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Address of caregiver

Relationship to policyholder	NRIC number
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Contact number (Handphone) (Office) (Home)	Email
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Bank account for benefits payment once claim is admitted

Note: For payment to third party (family member or caregiver), please complete the attached Letter of Undertaking & Indemnity.

Name of bank account holder	Bank account number
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Name of bank	Name of branch
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Details of dependant (for Care Secure only) or child below age 21 (for PrimeShield only)

Full name of dependant/youngest child	Date of birth (child)	Place of birth (child)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Birth certificate/NRIC number (Please submit copy of birth certificate/NRIC)	If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy): _____ <i>(Please submit copy of legal adoption papers)</i>
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Medical history

1. Have you ever been admitted to a hospital in the last 5 years? Yes No If "Yes", please give details of the medical conditions and when it started.

Condition	Date started (dd/mm/yyyy)

2. Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus) that you are suffering from.

3. Name and address of your regular doctor.

4. If disability is due to accident, please provide date of accident _____ (dd/mm/yyyy), and attach a copy of accident report.
 If no report is available, please describe: (a) nature of the accident; and (b) extent of injuries sustained.

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, its representative, agents (collectively "Income"), relevant third parties, referred to in Income's Privacy Policy which can be found at <https://www.income.com.sg/privacy-policy> and/or appointed distribution partners to collect, use, and disclose my/our personal data and information (including any updates and existing personal data that I have/had given to Income) (collectively "personal data") for the purposes of processing and administering the insurance application or transaction, providing me with financial advice and/or recommendation on products and services, managing my relationship and policies with Income including sending me corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in the Income's Privacy Policy.

Where personal data of a third party (for example personal data of my spouse, child, ward, parent or employee) is provided by me/us, I/we represent and warrant that I/we have obtained the consent of the third party to provide Income with their personal data for this application or transaction.

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;
- 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, the personal data will also include any subsequent information Income collects 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 practitioners.

I/we authorise, consent and agree to NTUC Income Insurance Co-operative Limited disclosing my/our personal data to the Government of Singapore and statutory boards and organisations approved by the Government of Singapore, for the purpose of determining my suitability and eligibility for public schemes (including, without limitation, schemes relating to healthcare, aged care, disability, social assistance, financial assistance, retirement, savings, insurance and/or disability insurance) when required.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

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.

Declaration and authorisation

If the Policyholder has previously been assessed by a doctor to lack mental capacity*, the Policyholder's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated Policyholder need not sign off/affix thumbprint.

* A separate doctor's memo should be submitted to indicate that the Policyholder lacks mental capacity, including the relevant medical reason(s).

1. I certify that the information in this form is true and complete and I have not withheld any material information.
2. I agree that this application shall form part of my application for ElderShield Supplement/Care Secure benefits.
3. I/We declare that I/we am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.
4. I confirm that I understand and agree to the 'Personal data use statement'.
5. For the purpose of policy administration including processing and investigating this claim (whether this application is accepted or refused), 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, reinsurer and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its service providers.
 - b. I authorise Income to collect from and/or disclose to and to exchange with any medical source, insurance office, reinsurer, or organisation any relevant information to do with me/us.
 - c. I authorise Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate my/our health status or condition in relation to this application and any claim in connection with this policy.
 - d. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of him/her.
6. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Full name of Policyholder	NRIC number	Signature or thumbprint of Policyholder	Date signed (dd/mm/yyyy)

To be completed if form is filled up by family member

Full name of family member	NRIC of family member	Relationship to Policyholder
Address of family member	Signature of family member	Date signed (dd/mm/yyyy)
Contact number (Handphone)	(Office)	(Home)

Important Note:

1. This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this letter will facilitate the prompt processing of your claim.
2. Please complete this form if payment is to be made to a Third Party.

To be completed by payee

To: Income

Part I: Letter of Undertaking & Indemnity

I/We declare that I am/we are the main caregiver(s) of the Policyholder, _____
Full name of Policyholder

_____ of NRIC number _____
NRIC number of Policyholder

Policy number _____

In consideration of Income agreeing, at the Policyholder's/my/our request to pay the benefits which the Policyholder is entitled to under Income's ElderShield Supplements or Care Secure insurance (" the Benefits") to me/us, I/we agree and undertake as follows :

1. That I/we will first use and apply the Benefits paid by Income for the care and benefit of the Policyholder.
2. That I/we will inform Income immediately upon becoming aware that the Policyholder has passed away or ceases to be entitled to the Benefits. I/we will repay any Benefits which the Policyholder is not entitled or ceases to be entitled to upon written demand by Income.

I/We agree and undertake that if I/we fail to make such repayment, I/we will fully indemnify Income against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred by Income as a result of my/our failing to fully repay the benefits or if Income has to enforce its rights under this Undertaking and Indemnity.

Part II: Direct credit authorisation

Kindly attach a copy of the bank book or statement showing the bank's name, branch and account number for our action.

I authorise Income to credit the Benefits into this account and to verify my/our account with the bank:

Full name of account holder(s) : _____

Name of bank : _____

Name of branch : _____

NRIC number :

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Account number :

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Details of payee (Age above 21 years old)

Full Name of payee	NRIC number	Contact number
Address		Nationality
Signature of payee	Relationship to Policyholder	Date signed (dd/mm/yyyy)
Full Name of Policyholder	Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)

For homes or institutions only (If benefits are to be made to the home or institution)

Full name of home or institution		Address of home or institution	
Full name of authorised officer	Contact number of authorised officer	Official stamp of home or institution	
Signature of authorised officer	Date signed (dd/mm/yyyy)		
Full Name of Policyholder		Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)