Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

Dear Customer, please email your claim to groupclaim@income.com.sg to avoid delay in the processing.

Group Hospital and Surgical Claim Form

Important notes

1. The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or medical report must be given at the expense of the employer or employee/patient.

2. Upon admission (if applicable), please sign the forms for CPF Medisave Deduction and CPF MediShield Life/Medisave-Approved Integrated Shield Plan and pay a deposit as requested by the hospital.

3. Please email the following documents to **groupclaim@income.com.sg** within 30 days of the patient's discharge from hospital:
   (a) Please complete all items in Section 1 and indicate as "N.A" if not applicable.
   (b) Copy of final hospital bills, doctor's bills and receipts of payment.
   (c) For admission into a government/restructured hospital, please provide the inpatient discharge summary/ambulatory form/hospital pre admission form.
   (d) For admission into a private/overseas hospital, please provide a copy of the itemised/detailed hospital bill with Section 2 completed by the attending doctor. If the attending doctor charges a fee for the completion of Section 2 the employer or employee/patient is responsible to pay the charges.
   (e) A copy of the employee's Work Permit or S-Pass. (For claims under WorkMedic Policy only.)
   (f) For bills that indicate any payment by Medisave-Approved Integrated Shield Plan, please provide a copy of the Shield Plan's settlement letter. Please ensure that all required documents are completed and submitted together with this claim form to avoid any delay in processing your claim.

4. When we pay an eligible claim, precedence shall be given in the following order:
   - Employer or employee if they have settled the eligible medical bills by cash
   - Medisave account as indicated in the tax invoices or bills
   - Patient's Medisave-Approved Integrated Shield Plan or CPF MediShield Life (if applicable) in accordance with the CPF Act.

Section 1 – To be completed by employer and employee/patient

Company name: _____ **Policy number:** _____

Particulars of employee or patient

Particulars of employee (as shown in NRIC, FIN or Passport)				
Full Name (as shown in NRIC, FIN or Passport)		NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality	Country of residence	Occupation	Date of employment (dd/mm/yyyy)	Contact number
Email address		Address		

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

Particulars of patient (If patient is a dependant of the employee) (as shown in NRIC, FIN, Passport or BC)				
Full Name (as shown in NRIC, FIN, Passport or BC)		NRIC, FIN, Passport or BC number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality	Country of residence	Relationship to employee ☐ Spouse ☐ Child	Occupation	

Medical Condition

1. Details of illness or injury		
a. Illness or injury	b. Describe symptoms	c. Date the symptoms started (dd/mm/yyyy)
d. Name of hospital	e. Surgical procedure	f. Period of hospitalisation or surgery (dd/mm/yyyy)
g. Name and address of referring General Practitioner or Clinic	h. Name and address of regular General Practitioner or Clinic	

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

a. Date and time of accident (dd/mm/yyyy)	b. Place of accident	c. Is it Work-related? ☐ Yes ☐ No

d. Give details of how the injury was caused by the accident. (Please enclose a copy of the police report, if any.)

e. Are these medical expenses claimable under your company's Work Injury Compensation Act Policy? ☐ Yes ☐ No

Other information

3. Have you claimed or do you intend to 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 from the other party. Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover if there is any excess amount paid to you.	☐ Yes ☐ No

Payee's details

4. Benefits should be made payable to: ☐ Employer ☐ Employee

Name of bank _____ Branch _____

Account number _____

[2] The bank details provided must be employee's/employer's bank account. If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under this claim and not be liable for any losses incurred by you.

Note: If there is a payment method agreed with your employer, payment will be based on the established method.

Name of payee (as shown in the bank account)	NRIC, FIN or Passport number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Personal data use statement (A photocopy of this authorisation is valid as an original copy)

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, 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 employee	Signature of employee	Date (dd/mm/yyyy)
Name of patient (if different from the employee)	Signature of patient (To be signed by patient's parent or legal guardian if patient is below 21 years old)	Date (dd/mm/yyyy)

Certification by employer

Name of employer	Policy number
Effective date of patient's insurance (dd/mm/yyyy)	Plan type
Date the employee last worked (dd/mm/yyyy)	

This is to certify that the details of the employee or insured member in this form is true and complete.

Name of authorised personnel	Signature and company's stamp	Date (dd/mm/yyyy)

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Attending Physician's Statement

Section 2 – To be completed by the Attending Doctor
(Applicable for hospitalisation or day surgery at private/overseas hospital or clinic)

Note: If the space provided is insufficient, please attach any written reports/diagnostic or lab-tests results.

1. Name of patient (as shown in NRIC, FIN, Passport or BC)	2. NRIC, FIN, Passport or BC number of patient
3. Date admitted (dd/mm/yyyy)	4. Date discharged (dd/mm/yyyy)

5. When did the patient first consult you for the condition? (dd/mm/yyyy)

6. Subsequent consultation dates (dd/mm/yyyy)

7. What were the complaints or symptoms presented during the first consultation?

8. When the patient first experienced these complaints or symptoms? (dd/mm/yyyy)

9. What was patient's diagnosis(es)?	First diagnosed date (dd/mm/yyyy)
1.	1.
2.	2.
3.	3.

Note: If there is more than one diagnosis, please advise whether they are related directly or indirectly to each other. Please provide us with details to your answer. ☐ Yes ☐ No

10. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 9?	Diagnosed date (dd/mm/yyyy)
1.	1.
2.	2.
3.	3.

11. Were any diagnostic or laboratory tests done? If 'Yes', please enclose a copy of the tests results.	☐ Yes ☐ No
12. Has the patient received any prior treatment for this condition before consulting you? If 'Yes', please state when and provide us with the name and address of doctor who treated the patient previously.	☐ Yes ☐ No
13. Was patient referred to you by a clinic or hospital? If 'Yes', please state when was the referral and name and address of the referring doctor.	☐ Yes ☐ No
14. Did patient suffer similar or related conditions in the past? If 'Yes', please indicate nature of problem, name and address of attending doctor and dates of treatment.	☐ Yes ☐ No
15. Has the patient ever suffered from any serious illnesses (e.g. heart conditions, kidney failure, stroke, cancer etc) prior to this admission? If 'Yes', please provide us with the diagnosis, first date of diagnosis, and name and address of doctor seen.	☐ Yes ☐ No

16. Date and type of operation or treatment performed. For surgery, please state surgical table and code. If no surgery was performed, please state treatment and medication given.		
17. Where 2 or more surgical procedures were performed, please specify whether they were done through the same incision.		
18. When was the patient <u>first</u> advised to have the surgery? Name and address of the doctor who advised the patient to have the surgery.		
19. Was the treatment medically necessary? If 'No', please give details.	☐ Yes	☐ No
20. Was the hospitalisation/surgery for the following treatment items, procedures, conditions, activities or their related complications?		
a) Health screening related examinations, admission for diagnostic purpose, genetic screening, treatment of a preventive nature, cosmetic treatment, surgery/treatment for obesity, correction of eye refraction, squint or other eye misalignment? If 'Yes', please give details.	☐ Yes	☐ No
b) Birth defects, congenital abnormalities, or developmental delay/learning disabilities in children? If 'Yes', please give details.	☐ Yes	☐ No
c) Psychological disorder, personality disorder, behavioural disorder, emotional or mental conditions or illness/injury resulting from such disorders? If 'Yes', please give details.	☐ Yes	☐ No
d) Elective abortion, pregnancy or complication arising from pregnancy, complications arising during or after childbirth? If 'Yes', please give details.	☐ Yes	☐ No
e) Infertility, sub-fertility, assisted conception, erectile dysfunction, impotence or contraceptive treatment? If 'Yes', please give details.	☐ Yes	☐ No
f) Venereal diseases, AIDS, AIDS related complex or infection by Human Immunodeficiency Virus (HIV)? If 'Yes', please give details.	☐ Yes	☐ No
g) Intentional, self-inflicted injuries or injuries resulting from attempted suicide? If 'Yes', please give details.	☐ Yes	☐ No
h) Drug addiction or alcoholism or illness/injury resulting from or under the influence of alcohol or drugs? If 'Yes', please give details.	☐ Yes	☐ No
i) Dental treatment, oral surgery, orthodontics, orthognathic surgery, oral and maxillofacial surgery or temporo-mandibular joint disorder? If 'Yes', please give details.	☐ Yes	☐ No
j) An accident? If 'Yes', please give details of the accident and whether it is work-related and whether police report was made.	☐ Yes	☐ No
21. Has patient fully recovered from the condition(s)? If 'No', what are the follow-up treatments required?		

Name and stamp of attending doctor	Signature of attending doctor
Date (dd/mm/yyyy)	Hospital or clinic's name and address