income made different

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an NTUC Social Enterprise

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) Original final tax invoices (itemised bills), bills or receipts showing the patient's name and date of treatment
   (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 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. Name (as shown in NRIC or Passport)		
1c. NRIC number or FIN	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 patient (Compulsory if patient is spouse or child of policyholder)

2a. Name (as shown in NRIC, Passport or BC)			
2b. NRIC, BC number or FIN	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) ________________			
☐ GP ☐ SP ☐ Others (Please specify) ________________			
☐ GP ☐ SP ☐ Others (Please specify) ________________			
☐ 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. ☐ Yes ☐ No

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.

Payment to be made by:

☐ Cheque

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

Note:
- If this is your first time requesting for direct credit, please submit a copy of your bank account details page for set up purpose.
- 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 form, I/we give my/our consent 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 the information (including any updates) for the purposes of processing and administering this insurance application or transaction, providing me with financial advice and/or recommendation on products and services, managing my relationship and policies with Income including 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 information of my spouse, child, ward or parent) is provided by me/us, I/we represent and warrant that I/we have obtained the consent of the third party to provide you with their personal data for this application or transaction.

The consent provided by me in this form is in addition to and does not supersede any consent which I may have provided previously in respect of the above purposes, unless my consent is withdrawn and notified to Income.

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 'Personal data use statement'.

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 agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name and signature of policyholder	NRIC number or FIN of policyholder	Date (dd/mm/yyyy)
Name and signature of patient (If different from policyholder and age above 21 years)	NRIC number or FIN of patient	Date (dd/mm/yyyy)