NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

SilverCare, Hospital Care, Specialcare, MerdekaCare insurance claim form

Important notice

- If we accept this form, this 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 it.
- 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)	

This claim is based on the policy below. Please tick accordingly.

☐ SilverCare ☐ Hospital Care ☐ SpecialCare (Autism/down syndrome) ☐ MerdekaCare

Personal details of policyholder

Name of policyholder (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
Contact number (Office) (Home) (Handphone)	Email	

Note: For death claim, to fill in the details of the person filing the claim under the policyholder.

Personal details of insured (Do not fill this in if it is the same as above)

Full name (as shown in NRIC)	NRIC 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**)

Details of incident, injury or illness

Date of incident (dd/mm/yyyy)	Time of incident ☐ am ☐ pm	Place of incident

Say what happened

Nature and extent of injury or illness sustained

1. Has the insured person previously suffered a similar injury or illness? ☐ Yes ☐ No
   If Yes, please give details.

2. How long was the hospital stay?

3. Please advise if your hospital or medical leave is finalised and completed? ☐ Yes ☐ No
   If Yes, please state the date the insured return to work (dd/mm/yyyy): _____
   If No, please state when the hospital or medical leave is expected to be completed (dd/mm/yyyy): _____

Other insurance cover (Please answer all questions.)

1. Does the insured have other insurance cover to refund medical expenses? ☐ Yes ☐ No
   If Yes, please give the name of the insurer and the policy number.

2. Does the insured's employer have other insurance cover (for example, Workmen's Compensation) for medical expenses? ☐ Yes ☐ No
   If Yes, please give the name of the insurer and the policy number.

3. Has a similar claim for medical expenses for this Injury or illness been made from the above insurer in 1 and 2? ☐ Yes ☐ No
   If Yes, when was the claim made?

Supporting documents

(A) If you are claiming for **Daily Hospital Income** or **ICU triple cover** [for hospital care only], please send us the following.

1. A copy of the final hospital bill
2. An inpatient discharge summary (if you have to stay in hospital)
3. A filled-in medical report (see 4th page of the claim form)

(B) If you are claiming for **medical expenses** or **ambulance fee**, please send us the following.

1. Original final hospital and medical bills as well as receipts for all the expenses
2. Inpatient discharge summary (if you have to stay in hospital)
3. A filled-in medical report (see 4th page of the claim form)
4. A copy of the reimbursement letter from another insurer or employer (if this applies)

(C) If you are claiming for **permanent disability, mobility aids, home modification, caregiver training** [for SilverCare, SpecialCare (Autism) and MerdekaCare only], **senior day care, home care, nursing service expenses or home-cleaning expenses** [for SilverCare and MerdekaCare only], please send us the following.

1. Original bills and receipts for all the expenses
2. Inpatient discharge summary (if you have to stay in hospital)
3. A filled-in medical report (see 4th page of the claim form)
4. Prescription from your doctor for a mobility aid (if this applies)
5. Referral letter by your doctor for admission to nursing home (if this applies)

(D) If you are claiming for **personal liability** [for SpecialCare(Autism) only], please send us the following.

1. Photographs of damage caused
2. Original purchase invoice or receipts of the damaged items
3. Letter or writ of summons from someone else

(E) If you are making a claim for **death** [for SilverCare, SpecialCare (Autism) and MerdekaCare only], please send us the following.

1. A copy of the death certificate
2. The autopsy report, toxicological report and coroner's findings
3. Proof of your relationship with the person who died

Policyholder or person claiming	Documents needed
Husband or wife	Marriage certificate
Parent	Birth certificate of person who has died
Child	Birth certificate of policyholder or person claiming
Brother or sister	Birth certificate of person who has died and policyholder or person claiming

4. Last will of the person who died (if they left a will) or letter of administration (if there is no will)

This is not a full list and we may ask for other documents.

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 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 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.

Medical report

The doctor must fill this in.
(You will have to pay any costs involved in the doctor providing this report.)

Name of Patient	NRIC number

1. Final diagnosis

2. Date of diagnosis (dd/mm/yyyy)

3. Nature of injury or condition and the extent of the injury

4. Was the condition caused by an accident? ☐ Yes ☐ No

   a) If Yes, please give the date of the accident (dd/mm/yyyy): _____ Time of accident: _____ AM/ PM

   Describe the accident

   _____

   b) If No, please state the cause of condition:

   _____

5. Was any surgery carried out for this condition? ☐ Yes ☐ No
   If Yes, please provide nature of treatment/name(s) of surgical procedure(s), surgical code & table.

6. Was the insured under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No
   If Yes, please state the blood alcohol content or type of drug and the quantity consumed.

7. Is the Insured's condition self-inflicted or as a result of attempted suicide? If Yes, please provide details. ☐ Yes ☐ No

8. Is the injury likely to cause loss of use of the injured part? ☐ Yes ☐ No

9. Is the loss likely to be permanent? ☐ Yes ☐ No
   If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.

For illness (if this applies)

1. Date of symptom first started (dd/mm/yyyy)	2. When did the patient first consult you about this condition?

3. Details of present symptoms, nature and date of treatment given

4. What were the underlying conditions? Please provide date of diagnosis

5. Doctors previously consulted by the patient for the above condition:

Name of doctor	Date of consultation	Name of clinic or hospital	Address

6. Has the patient fully recovered from the condition? If No, what follow up treatment are needed?

_____ _____
Signature of doctor Date (dd/mm/yyyy)

_____ _____
Name and position Name and address of clinic or hospital