



Claim form for Child Illness Rider

Important notes

1. The acceptance of this form is not an admission of liability on the part of Income.
2. Medical report must be given at the expense of the policyholder or insured.
3. Please ensure that both Section 1 and Section 2 of the claim form are completed before you submit the claim.

Section 1 – To be completed by policyholder or insured

Particulars of policyholder or insured		
Full name of insured (as shown in NRIC/Birth Certificate/Long-Term Pass)	Policy number	NRIC/Birth Certificate/ Long-Term Pass number
Address of insured		
Full name of policyholder (as shown in NRIC/Passport/Long-Term Pass)	Relationship to insured	NRIC/Passport/Long-Term Pass number
Residential address of policyholder		

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 any of your existing policies with the new contact particulars.

Record of medical consultations	
1. Please provide details of any other doctors or specialists the insured has consulted in connection with this illness or injury	
a) Name and address of hospital or clinic	b) Date of first consultation
2. Name and address of insured's regular doctor	
3. Please tick the condition which you are claiming for.	
<input type="checkbox"/> Severe asthma <input type="checkbox"/> Bone marrow transplant <input type="checkbox"/> Still's disease <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Mental retardation due to sickness, injury or accident	<input type="checkbox"/> Leukaemia <input type="checkbox"/> Insulin-dependent diabetes mellitus <input type="checkbox"/> Rheumatic disease with valvular impairment <input type="checkbox"/> Haemophilia <input type="checkbox"/> Accidental fracture of skull, spine, pelvis or femur

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

1. I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.
2. I declare that the answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information.
3. 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. I further confirm on the representation and warranty made in the PDUS.
4. I confirm that I am authorised to disclose information (including personal information) about the insured if this claim is made on behalf of them.
5. For the purpose of administering and processing my claim, I 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 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 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 agree that a copy of the authorisation in this form is valid and binding as an original copy.

6. I understand that I must give Income all documents, authorisations or information required by Income to assess the claim. If I fail to co-operate with Income in administering and processing the claim, I am aware that the assessment of the claim may be delayed or Income may reject the claim.
7. I agree that if I or any [#]Relevant Person is found to be a ^{*}Prohibited Person:
 - if any policy is issued, you are entitled to end this policy, not pay any benefit or not allow any transaction, such as surrender and assignment, to be carried out under this policy. You will not refund any unutilised premium when this policy is ended.

Your decision in every respect of the above will be final.

I will inform you immediately if there is any change in my or any Relevant Person’s identity, status or identity documents.

[#] *Relevant Person* includes insured, trustee, settlor, beneficiary, assignee, nominee, payee, mortgagee, financier of this application/policy, and in relation to an entity, its director, partner, manager, person having executive authority, authorised signatory, shareholder or beneficial owner.

^{*} *Prohibited Person* means a person or entity who is, or who is [^]Related to a person or entity:

- i. subject to laws, regulations or sanctions administered by any inter-government, government, regulatory or law enforcement authorities of any country, which will prohibit or restrict you from providing insurance or carrying out any transaction under this policy, or
- ii. who is involved in any terrorist or illegal activities or placed on sanctions listing or issued with freezing order.

[^] *Related* includes relationships such as parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling, adopted sibling, parent-in-law, child-in-law, sibling-in-law, cousin, uncle, aunt, grandparents, niece, nephew, grandchild, employee, employer, associate, parent company, subsidiary and shareholder.

8. I 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.

_____ Full name and signature of policyholder	_____ NRIC/Passport/Long-Term Pass number of policyholder	_____ Date signed (dd/mm/yyyy)
_____ Full name and signature of patient or insured person (If different from Policyholder and age above 21 years)	_____ NRIC/Birth Certificate/Long-Term Pass number of patient or insured person	_____ Date signed (dd/mm/yyyy)

Please ensure that “Attending Physician’s Statement for Child Illness Rider” on the next page is completed.

Attending Physician's Statement for Child Illness Rider

Section 2 – To be completed by the attending doctor

Part 1: General Information

1. Are you the patient's usual medical doctor? If 'Yes', over what period do your records extend to?
2. When did the patient first consult you for this condition?
3. When you first saw the patient, what were the symptoms presented and how long did they last? Please state the date that the symptoms began.
4. In your opinion, how long has the patient been having these symptoms? Please provide reasons.
5. Did the patient consult any other doctors for these symptoms before consulting you?
6. What is the diagnosis? Please provide full details of the diagnosis, including the date of diagnosis.
7. When did the patient or the parent first become aware of the condition?

Part 2: Details of child's illness (Please fill in the appropriate section.)

1. Severe asthma

a) Has there been a history of status asthmaticus within the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Did the patient exhibit significant and continuous reduction in exercise tolerance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Were there chest deformities resulting from chronic hyperinflation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Was there a need for medically prescribed oxygen therapy at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Was the patient on continuous daily use of oral corticosteroids (for at least six months)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Leukaemia

a) Please provide details of any chemotherapy or radiotherapy treatment provided, including the dates and type of treatment provided.
b) Please provide details of all investigations performed.

3. Bone-marrow transplant

a) What is the underlying condition for which the patient needs a bone-marrow transplant?	
b) Has the patient had a bone-marrow transplant? If 'Yes', please provide the date of the transplant and the name of the hospital where the transplant was performed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) If the patient has not had a bone-marrow transplant, has the patient been confirmed as accepted on the official waiting list of the medical or health authorities in Singapore for a transplant, as a recipient? If 'Yes', please provide the date and the details where the patient was placed on a waiting list.	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Insulin-dependent diabetes mellitus

a) Was the presence of severe diabetes mellitus characterised by: i. loss of plasma insulin levels; ii. episodic ketoacidosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
b) Please give details if the patient is insulin-dependent and enclose a copy of the blood and urine test results.	
c) Was there evidence of decreasing C-peptide? Please provide details.	
d) Please give details of all investigations done and treatment prescribed.	

5. Rheumatic disease with valvular impairment

a) Was there impairment or damage to one or more heart valves and was this supported by an echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Was there evidence of a history of rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Please give details of any group-A streptococcus infection with supporting evidence.	
d) Please provide details of all investigations carried out and enclose copies of the results of the echocardiogram and laboratory investigations.	

6. Kawasaki disease

a) Was there cardiac involvement with dilation or aneurysm formation in coronary arteries which lasted at least six months after the initial acute episode? If 'Yes', please provide details including the date it began and how long the coronary artery dilation or aneurysm formation lasted. Please enclose copies of investigations carried out confirming this.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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7. Haemophilia

a) Was the condition mild, moderate or severe?	
b) Was the clotting factor VIII less than 1%?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Was the clotting factor IX less than 1%?	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Still's disease

a) Does the patient show the features of Still's disease? Please provide details.	
b) Does the patient need a knee or hip replacement? If 'Yes', please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Please enclose copies of all laboratory test results, including blood-test results.	

9. Mental retardation due to sickness, injury or accident

a) Was the condition caused by sickness, injury or accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) If the condition was due to injury or accident: i. please provide the date of the accident and give details of the circumstances leading to the injury or accident.	
ii. Were there any contributory factors leading to the injury or accident? (For example, the influence of alcohol or drugs, self-inflicted injury, etc.)	

c) If the condition was due to sickness: i. please provide the date the sickness began.	
ii. what were the underlying conditions?	
d) Has the condition continued without interruption for at least six months in a row after diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Was the condition caused by congenital illness or condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Accidental fracture of the skull, spine, pelvis or femur

a) Was the patient's condition due to an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Did the accident result in a fracture of the skull, spine, pelvis or femur?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Did the fracture involve the insured staying in hospital for treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Was the patient's condition a hairline fracture which does not involve the periosteum or the articular surface?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Was the patient's condition due to self-inflicted injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Was the patient's condition caused by drug or alcohol abuse or misuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Please provide details of the accident.	
i. Date of accident (dd/mm/yyyy):	
ii. Time of accident	
iii. Place of accident	
iii. Describe the extent of the injury and give details of the anatomical site involved.	
h) Please enclose copies of the X-ray.	

Other useful information

- Please provide us with any other information that will be helpful in assessing this claim.
- We would appreciate it if you could enclose copies of all relevant diagnostic and laboratory test results.

Signature of doctor or medical officer-in-charge

Date (dd/mm/yyyy)

Name (in block letters)

Address and official stamp of hospital or clinic