NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
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Enquiries: www.income.com.sg/enquiry

i50 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 them.
- 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)	

Personal details of policyholder

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)
Address		Occupation/Business	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

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)
Relationship to policyholder or person claiming ☐ (please give details) _____ ☐ Employee		Occupation	Nationality

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**)

For PA 360 and Home 360:

Medical or accident claim details (please answer all questions.)

1 Details of injury or infectious disease

Is the condition or disability suffered due to: ☐ Accident ☐ Infectious disease

a If the condition or disability is due to infectious disease, please provide:

(i) the diagnosis _____

(ii) the date your symptoms started (dd/mm/yyyy): _____ / _____ / _____

(iii) a detailed description of all symptoms and the nature of the medical condition or disability.

_____

b If the disability is due to accident, please provide:

(i) the date of the accident (dd/mm/yyyy): _____ / _____ / _____ (ii) the time of the accident : _____

(iii) where this happened _____

(iv) a detailed description of the nature of your injuries or disability suffered

_____

(v) a detailed description of the accident (Please enclose a copy of the police report, if any.)

_____

_____

_____

c (i) Has the insured been given hospital or medical leave? If 'Yes', please give the start and end date of the hospital or medical leave. ☐ Yes ☐ No

Start date (dd/mm/yyyy): _____ End date (dd/mm/yyyy): _____

(ii) 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): _____

2 How were you admitted to the hospital?

☐ Referral by a general practitioner, specialist or other hospital (please delete)
Please give the name and address of the referring doctor or hospital.

_____

☐ A & E department

3 Please provide the name, contact number and address of the doctor who is treating you for your current condition or injury.

4 Was any surgery carried out for this condition? If Yes, please provide details below. ☐ Yes ☐ No

Surgical operation or procedure	**Date of operation or procedure** (dd/mm/yyyy)	**Surgical code or table** (please ask your doctor)

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

6 Has treatment been completed? If no, please say when the treatment is expected to be completed. ☐ Yes ☐ No

7 ☐ Others sections
For any other claim which does not fall within the sections shown above, please provide details of the claim. If there is not enough space below, please attach another page.

_____

_____

_____

Other insurance coverage (Please answer all questions.)

1 Does the insured have other insurance cover for refunding medical expenses? ☐ Yes ☐ No
If Yes, please give the name of the insurer and list the policy plan and sum assured:

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 list the policy plan and sum assured:

3 Has a similar claim for medical expenses for this incident been made from the insurers named above in 1 and 2? ☐ Yes ☐ No

For Home 360 only:

Details of occurrence

Date of Incident (dd/mm/yyyy)	Time of Incident	Place of Incident

1 Please describe how the incident occurred.

2 Please give particulars of person(s) responsible for the loss/damage/injury?

3 Have you made a claim upon the person responsible for the loss/damage/injury. ☐ Yes ☐ No

4 Details of occurrence.

5 Was a police report made? If so, when and where was it made?

6 How was entry into premises gained? Were there any signs or evidence of forcible and violent entry?

7 Was the premises occupied at the time of the occurrence? If not, when was it last occupied?

8 Please give particulars of eyewitness(es), if any.

9 Please give us particulars of other person(s) other than yourself who have any interest in the property concerned and state the nature of their interest.

10 Is there other insurances (e.g. HDB or MCST Fire Insurance) covering the property concerned? ☐ Yes ☐ No
If so, please state the name of insurer and policy number.

11 Ownership status	Name of Mortgagee (if applicable)
☐ Owner ☐ Tenant ☐ Mortgagee	

12 Please state the current total value of all the property insured under the policy.

Liability claim (Complete this section ONLY if claim is made against you)

1 When were you first notified of the incident?

2 Please give us details if loss/damage/injury is attributed to defects in your premises, equipment or plant.

3 If anyone has been injured, please furnish:

a) Full particulars of injured person

_____

b) Details of injuries sustained

_____

4 Has any claim been made against you? If so, by whom?

Note: No payment, offer or promise of any payment or admission of liability should be made. All letters from third parties should be forwarded to us immediately upon receipt.

Claim details

Description of item	Details of damage/loss	Date (dd/mm/yyyy) purchased/incurred	Cost S$	Amount claimed S$

Supporting documents for PA 360

The below documents which have been **marked** will be enclosed with the claim form.

☐ **Death Claim:**

☐ 1 For death in Singapore – copy of death certificate

For death outside Singapore –

(a) certified true copy of death certificate by your lawyer or any notary public

(b) Letter from Immigration and Checkpoint Authority (ICA) - this letter is issued by ICA for Singaporeans or permanent residents (PR) who died overseas. It confirms they saw the Singapore IC, passport and overseas death certificate

(c) Repatriation report (if the body was sent home to Singapore for cremation or burial)

☐ 2 Autopsy report, toxicological report or coroner's findings

☐ 3 Proof of policyholder's or claimant's relationship to 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 certificates of person who died and policyholder or person claiming

☐ 4 Newspaper clipping and police or accident report (if death was due to accidental or violent causes)

☐ 5 Last will of deceased (if they had left a will) or letter of administration (if there is no will)

☐ 6 Estate duty certificate

☐ **Permanent disability claim:**

☐ 1 Medical report - Attending doctor to complete the attached medical report form

☐ 2 Medical report stating clearly the start, cause, extent of permanent disability and nature of injury or illness

☐ 3 Newspaper clipping and police or accident report
(if total and permanent disability or permanent incapacity was due to accidental or violent causes)

☐ **Medical expenses claim:**

☐ 1 Medical report - Attending doctor to complete the attached medical report form

☐ 2 Medical reports or laboratory reports or inpatient discharge summary
(stating clearly the start date, cause, extent of permanent disability (if this applies) and nature of injury or illness)

☐ 3 For a stay in hospital (if this applies and the claim is eligible) - Final hospital bill and receipt of payment

☐ 4 For outpatient treatment (if this applies and the claim is eligible) – Itemised medical bill and receipt of payment

☐ 5 Newspaper clipping and police or accident report

☐ 6 If items 3 and 4 have been given to another insurer or employer, please provide:

☐ (a) a certified true copy of the bills by the insurer or employer;

☐ (b) a reimbursement letter or payslip reflecting the co-payment by the insured or the employer; or

☐ (c) a discharge voucher or settlement advice by the insurer

☐ **Weekly cash claim**

☐ 1 Medical report - Attending doctor to complete the attached medical report form

☐ 2 Medical reports or laboratory reports or inpatient summary
(stating clearly the start date, cause, extent of permanent disability (if this applies) and nature of injury or illness)

☐ 3 Newspaper clipping and police or accident report

☐ 4 Medical leave certificate

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

Supporting documents for Home 360

The below documents which have been **marked** will be enclosed with the claim form.

☐ Police report/investigation results & incident report

☐ Photographs of damage

☐ At least 2 quotation(s) for repair/replacement of the lost or damaged property

☐ Assessment report from repairer on the cause and extent of the damaged property

☐ Invoices/purchase receipts of lost or damaged property

☐ Letters/Writ of Summons from third party

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.

Signature: _____ Signature: _____

Name of policyholder: _____ Name of insured: _____

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