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

Personal mobility guard 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)
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 (No need to fill this in if the information is the same as above.)

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

1. Date & time of occurrence	2. Place of occurrence
3. Describe circumstances in detail	
4. A detail description (type, brand & model) of bicycle or personal mobility device you were using at the time of accident.	
5. Name & contact number of person who witnessed this occurrence	
6. Is there any other insurance covering this incident? ☐ Yes ☐ No If Yes, please state name of insurance company, policy number and amount recoverable.	

Type of claim

Please tick off the items which you are attaching for this claim. We may ask for more documents to assess this claim.

A. ☐ **Personal Accident** **B.** ☐ **Medical expenses for injury due to an accident**

1. Nature of injury

2. Did these injuries result in permanent disability? If Yes, please get your attending medical practitioner to complete the attached Attending Medical Practitioner Form. If no, please provide the details. ☐ Yes ☐ No

3. Amount claimed

Supporting documents required (or attached):

- ☐ Original medical bills
- ☐ Medical report or discharge summary on onset date, cause, extent of permanent disability (if applicable) and nature of injury
- ☐ Police report
- ☐ Death certificate, autopsy report and coroner's findings (death claim)
- ☐ Proof of relationship between deceased and claimant (death claim)

C. ☐ **Personal liability**

1. When were you first notified of the incident?

2. If anyone has been injured, please furnish:

   a) Name, NRIC number and Address of injured person _____

   _____

   b) Details of Nature of Injury / Extent of Damage _____

   _____

   _____

   _____

3. Has anyone made a claim 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.

Supporting documents required (or attached):

- ☐ Police report/investigation results
- ☐ Letters, writ of summons from third party with supporting documents if any (eg. Invoices of items, quotation for repair)

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.

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Attending Medical Practitioner's Statement

Part 1 (To be completed by the Insured)

Policy number	Plan type	Claim number
Name of Insured (as shown in NRIC)		NRIC number
Address of Insured		
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number
Address of next-of-kin		

Authorisation

I agree and authorise:

a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by Income; and

b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer, or organisation or person.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

Height of Insured _____ m Weight of Insured _____ kg

The above readings were taken on this date (dd/mm/yyyy) _____ /_____ /_____

1. a. Are you the Insured's usual doctor?	☐ Yes ☐ No
b. Over what period do your records extend? Start date (dd/mm/yyyy) _____ /_____ /_____ End date (dd/mm/yyyy) _____ /_____ /_____	
2. What is the diagnosis for the Insured's present illness/injury?	
a. What is the exact date of diagnosis? (dd/mm/yyyy) _____ /_____ /_____	
b. Please provide us the name and address of the doctor where the diagnosis was first made.	
c. Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
d. Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.	☐ Yes ☐ No

3. a. Was the condition caused by an accident? If "Yes", please state: Accident date (dd/mm/yyyy) _____ /_____ /_____ Accident time _____	☐ Yes ☐ No
b. Describe the accident.	
c. Was the accident reported to the police? If you happen to possess a copy of the police report, please enclose it.	☐ Yes ☐ No
d. Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	☐ Yes ☐ No
e. Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	☐ Yes ☐ No

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? If "Yes", please provide details. ☐ Yes ☐ No

Name of referring doctor	Name & address of clinic/hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the referral

6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details. ☐ Yes ☐ No

Name of doctor	Name & address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. a. Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy, etc.).

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

b. Has the Insured been compliant with the treatment suggested? If "No", please provide details. ☐ Yes ☐ No

c. Are there plans for other forms of treatment? If "Yes", please provide full details. ☐ Yes ☐ No

Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment

e. Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following: ☐ Yes ☐ No

i. Type(s) of treatment that would improve Insured's condition

ii. How would the treatment improve Insured's condition and to what extent?

iii. Why did Insured reject the treatment?

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

a. Please describe the nature and severity of the Insured's condition.

b. Is full recovery expected? ☐ Yes ☐ No

If "Yes", please state approximate date (dd/mm/yyyy) _____ /_____ /_____

If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ /_____ /_____

c. At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). ☐ Yes ☐ No

Date of last assessment (dd/mm/yyyy) _____ /_____ /_____

i. Range and strength (please indicate power grading of limbs)

ii. Gait and balance

iii. Coordination

iv. Movement

d. Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? If "Yes", please provide details. ☐ Yes ☐ No

10. Is the Insured able to perform all the 6 Activities of Daily Living (feeding, mobility, transferring, washing/bathing, dressing and toileting/continence) independently? ☐ Yes ☐ No

a. If "No", what are the activities the Insured cannot perform independently? Does the Insured require minimal or maximum assistance in these activities?

b. Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy). ☐ Yes ☐ No

11. What was the Insured's occupation before his disability?

a. What was the nature of his duties?

b. Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why. ☐ Yes ☐ No

12. a. Has the Insured returned to his usual occupation? ☐ Yes ☐ No

b. If "No", would the Insured be able to return to his usual occupation at a later date?

☐ Not able to determine presently (Go straight to Question 15)

☐ Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) _____ /_____ /_____

☐ No – Not possible to return to usual occupation even at a later date

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider **in the future**?

☐ Yes Examples of such occupation(s) are: _____

Expected date when his condition allows him to engage in these occupation(s) is:

(dd/mm/yyyy) _____ /_____ /_____

If the Insured is unable to engage in sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.), please provide us the reason(s).

_____

_____

☐ No The Insured is unable to take part in any paid work for the rest of his life.

14. If you have answered "No" to Question 13, please state the date when the Insured is considered not able to take part in any paid work for the rest of his life.

(dd/mm/yyyy) _____ /_____ /_____

15. Is the insured physically or mentally disabled from ever continuing in any employment (including self-employment)? For avoidance of doubt, the difficulty in finding employment is a separate consideration and should not influence your answers to the questions below. ☐ Yes ☐ No

If "Yes", please provide us with reason(s) for your answer and the date (dd/mm/yyyy) when the Insured is permanently incapacitated.

Reason(s):

_____

_____

Date: (dd/mm/yyyy) _____ /_____ /_____

16. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) _____ /_____ /_____

17. Please tick (✔) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

a. Total and permanent loss of sight

The loss must be permanent and irreversible, even with the use of visual aids.

☐ Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

☐ Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

b. Severance of limbs/total loss of use of limbs

☐ Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above elbow	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

☐ Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above knee	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

☐ Total loss of use (defined as Total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

18. a. Please describe the Insured's mental and cognitive abilities.

b. Is the Insured mentally incapacitated in accordance to the Mental Capacity Act? ☐ Yes ☐ No

c. If "Yes" to Question 18b above, please state the date when the mental incapacity started.

(dd/mm/yyyy) _____ /_____ /_____

19. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

20. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation. ☐ Yes ☐ No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

21. Please provide us with any other information that will be helpful in the assessment of this claim.

_____ _____

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

_____ _____

Name and qualification (printed) | Address and official stamp of clinic/hospital